Section 1: Transformation and Quality Program Details

A. **Project short title**: Project 173: Community Housing Needs

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 173

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☒ Neighborhood and build environment ☒ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In prior projects, YCCO has built an understanding of existing housing-related resources, formed a housing-specific workgroup of community partners, identified key housing initiatives to invest in, and identified best practice for collecting housing data on YCCO. YCCO has identified the following existing housing supports associated with YCCO partners. This does not include shelters or other unsupported housing:

Type of housing	Name	Capacity	Current or future
Psychiatric Crisis Stabilization	Bridges	5-6/day	current
	Peer Assisted Crisis Program	5/day	current
Supportive Housing (permanent)	Sunnyside	15 unit	current
	Homeport	14 unit	current
	Baker Field Transitional Apts.	8 unit	current
	Bridges 18-month Transitional	1 person	current
	Aspen Ridge	16 unit	current
	Reed House	3 units	current
Supported Housing (permanent, integrated)	Deskin Commons	8 units	current
	Rental Assistance	15 slots	current
	Forensic Rental Assistance	5 slots	current
	Fast Track Vouchers	varies	future
Day Management Treatment	Day House	varies	current
	Panther House	varies	current
Transition Treatment Recovery	Cozine Creek	varies	current
	Baker Creek	varies	current
Peer-supported recovery housing	Sheridan Housing Project	72 unit	future
Motel-based housing development	Turnkey Project	55 unit	future
Affordable housing development	HAYC Development	76 unit	future

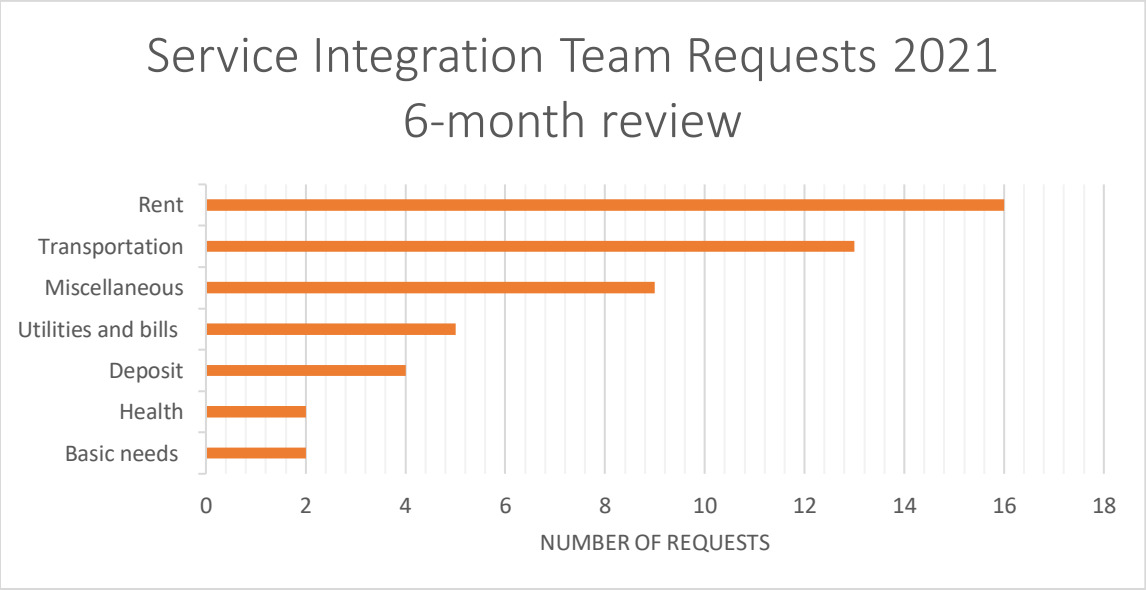
YCCO convened a workgroup that meets monthly, composed of the main housing-focused organizations in the YCCO service area: Housing Authority of Yamhill County, Yamhill County Health and Human Services, and Yamhill Community Action Partnership. This workgroup identifies opportunities and risks with local needs and housing gaps, as well as

coordinates resources. This group also makes recommendations for YCCO housing-directed social determinants of health funding, which go through the Community Advisory Council for review and recommendation.

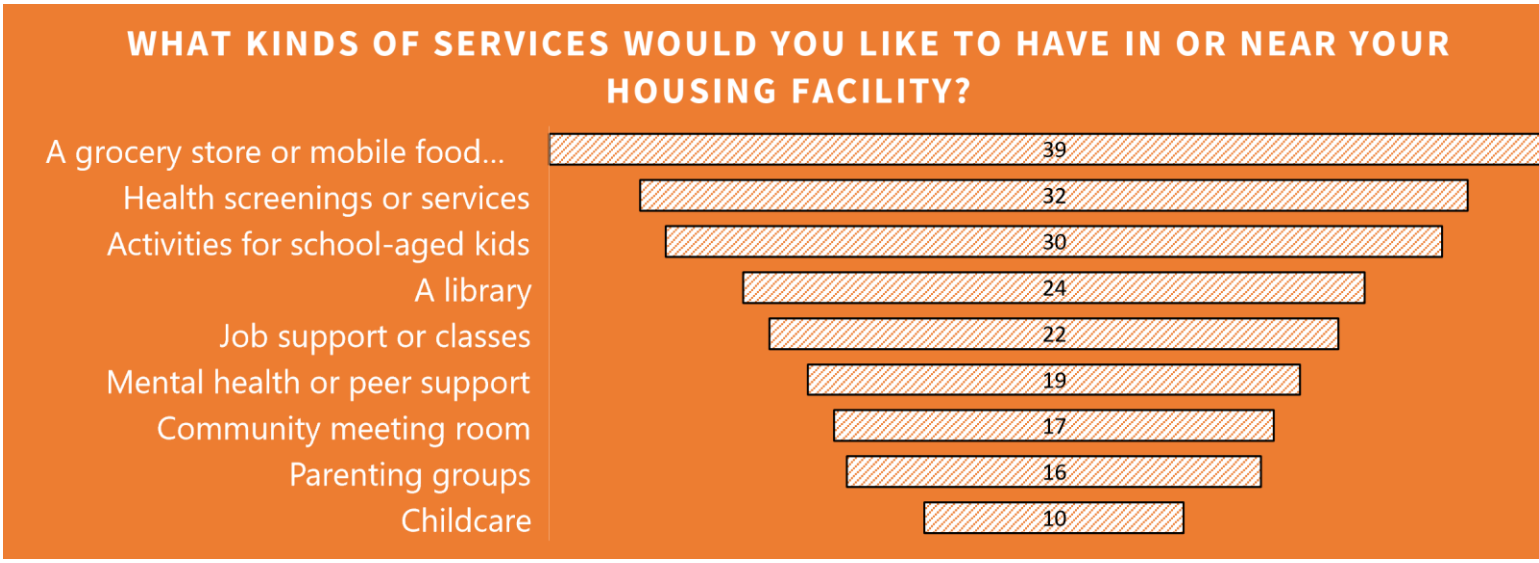
In the past project cycle, YCCO encountered a series of barriers in identifying a workflow for identifying YCCO members based on their utilization or referral to supported housing programs. Shifts to the remote space and competing priorities, as well as some changes in partnership, staffing, and data systems delayed progress in achieving this goal. In 2022, YCCO has developed new lines of communication and is identifying best practices for tying member data to housing utilization.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Coordinated care organization initiatives continue to become more aligned and integrated with social and community needs. As member supports for their social determinants of health increase, YCCO is committed to also building more robust systems to track and monitor the distribution and impact of these supports. YCCO has historically spent a large portion of its HRS Flex funds on housing-related supports, and its HRS-funded Service Integration Teams funding on housing/utility/rent supports. These needs have increased and been exacerbated by the pandemic, which has also amplified the need to understand and follow up on these needs using streamlined data and referral systems.



Through partnership with Yamhill County Health and Human Services, YCCO is expanding the available affordable housing in the community by funding the Sheridan Housing Project, a 72-unit supportive housing facility, but is also partnering to better integrate housing supports with behavioral and medical health support. Based on the prior project's assessment, a series of housing supports are offered, but there is not clear data about what additional needs are present for those individuals housed. A 2020 survey of YC Housing Authority complex residents, most of whom were in affordable housing units, indicated these main needs:



While housing is a key social determinant of health, this project aims to ensure that not only are residents housed, but offered coordinated care supported by streamlined data sharing and analytics. YCCO will also continue to develop internal processes for identifying members referred to housing resources through its CHW Hub, and create regular analytic reports.

E. **Brief narrative description**:

This project will build on previous relationship-building, program development, and data system exploration to establish clear processes for collecting, sharing, and analyzing housing data associated with YCCO members.

The project will have two key components:

- Develop a system to indicate which YCCO members have been engaged with supportive housing services and integrating this into HHS member reports and
- develop internal processes for documenting, referring, tracking, and analyzing member referrals into housing-related services.

This process will be informed by the 2019 Community Health Improvement Plan and the ongoing new Community Health Assessment, which is prioritizing reaching homeless or formerly homeless populations to understand the specific needs they have. YCCO will use this data to inform its own housing investments, referrals, and monitoring. Because many of the housing investments are driven through the SHARE initiative, the Housing Partners Workgroup and Community Advisory Council will receive regular updates on reports and progress.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Develop data marker for YCCO members who have engaged with supportive housing programs and analyze YCCO member engagement with those supports.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Improve rates of specific member populations accessing dental care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 YCCO members are currently identified	100% of YCCO members housed in	12/31/2022	50% of YCCO members housed in	12/31/2023

with housing flag out of 0 members currently housed in Sheridan Housing Project	the Sheridan Housing Project are reported to YCCO		Sheridan housing project who identify a need are referred to YCCO or HHS for service provision	
Monitoring measure 1.2	Ensure documentation of housing status in CIM			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 YCCO members engaged with HHS-supported housing outside of Sheridan are documented in CIM	3/13 HHS full time housing units document engagement in CIM	12/31/2022	10/13 housing units document engagement in CIM	12/31/2023

Activity 2 description: Support internal member services and operations staff to refine processes for tracking and referring to housing-related resources; develop system for regular analysis and reporting housing-related services funded through Flex investments.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Develop regular reports regarding housing resource, referral, and support needs

Monitoring measure 2.1				
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Departments monitor housing-related spending but no analysis is completed regularly	Annual housing analysis report is developed	12/31/2022	Annual housing report is developed and stratified by demographics	12/31/2023

A. **Project short title**: Project 174: Oversight & Monitoring of Member Language Accessibility

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: **174**

B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): Access: Quality and adequacy of services
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☒ Education
☐ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

CCOs are required under Federal and State rules to provide culturally and linguistically appropriate services to members at no charge. While these requirements are written and implemented in a variety of policies, procedures, handbooks and contractual agreements, the quality and consistency of the delivery of these services is partially unknown. Grievance and customer service data does not indicate significant reported barriers in these areas.

Successes of the past year include:

Activity 1: Continue fielding provider survey to learn how language services are requested, acquired, documented/tracked and assess for quality. Integrate these collection tools into ongoing network monitoring and oversight (CLAS Standard 10).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Provider survey developed and piloted with 15 PCPCH providers with 73% response rate. (11/15)	100% response rate from PCPCH providers 60% response rate from provider network in whole	12/31/2021		

The project involved the development and administration of a provider accessibility survey. The survey covered topics on identification of needs for language support and accommodations for a disability, on intake forms and collection methods, utilization of language services and accommodations for a disability, and procedures for staff training, monitoring and reporting. Response rates were 100% from PCPCH providers, with 10 dental clinics and 31 behavioral health clinics responding. With these responses, YCCO felt confident in moving forward with the information given from this sample of partner clinics.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

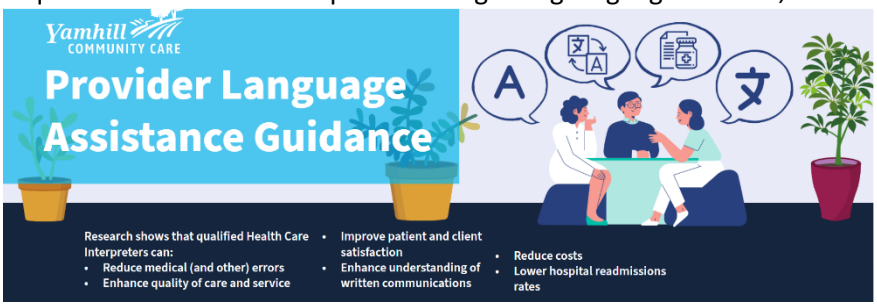
The Health Equity Plan goal of providing services that are culturally and linguistically appropriate and accessible is an evolving long-term goal. This past year's strategies to further this goal included:

- The assessing provider and the member needs through the collection of language access data, provider accessibility survey, and facilitated conversations with the community Advisory Council and community members.
- Development and dissemination of a provider toolkit to support Meaningful Language Access.
- Offering training and technical assistance to staff and community providers on best practices and resources available to provide culturally and linguistically appropriate care.

Based on language access data collected and reported in 2020, approximately 44% (1612 unique members) who identify as speaking a language other than English received interpretation services from a qualified/certified interpretation source. To supplement this information, YCCO conducted a provider survey to determine what accessibility services

were offered to patients. One of the goals of this survey was to reach a wide range of providers, and YCCO improved its survey range from only a select number of primary care providers in project year one, 2020, to more than 50 physical, behavioral, oral health and specialty care providers. This survey helped YCCO understand in more detail provider capabilities in offering assistive service, staff training and protocols, and established policies and procedures. A copy of the accessibility survey (Accessibility Survey 2020) is attached for reference. This survey revealed that likely additional language services are being offered through providers directly or through office staff and are not being captured or reported. It is unknown if these language supports meet the standards of qualified or certified language services. Further data collection strategies to capture all language services is a long-term goal.

In 2021, YCCO developed a Provider Language Access Toolkit, which shares state and federal laws and contractual requirements for Medicaid providers regarding language services, as well as best practices for offering these services.



This toolkit was piloted in a CME event on language access with ten attendees, sent out widely to the provider network, and posted publicly. A staff-facing supplement was also developed to ensure staff can both meet members' needs in direct encounters and advise providers appropriate on the processes for accessing language vendors.

E. **Brief narrative description**:

Part of the lack of language services and access data comes from provider reporting. Providers rarely use interpreter codes because they are not reimbursed, and the provider accessibility survey reveals gaps in both knowledge about language service requirements and ability to monitor services. Current providers using T1013 codes are very limited; only three were identified in 2019-2020.

Billing Provider Utilizing T1013 code	**2019**	**2021**
Pediatric clinic 1		6
Pediatric assessment center	3	
Pediatric clinic 2		1

YCCO has also identified which clinics have the highest rate of non-English speakers, and will prioritize those in technical assistance and outreach, to ensure members needing interpretation services are receiving the most appropriate care.

Based on review of the comprehensive Accessibility Survey fielded with physical, behavioral, and oral health providers, 36 clinics were identified as needing extra support based on at least one answer, with 4 clinics responding to multiple questions with answers that warranted follow-up. These ranged from clinics reporting that they use volunteers or untrained staff to provide language assistance to

Assigned PCP (12/14/21)	Total Members	Count Members by Spoken Language			%		
		English	Spanish	Other	English	Spanish	Other
[redacted]	6,283	5,211	982	90	82.9%	15.6%	1.4%
	5,797	4,860	827	110	83.8%	14.3%	1.9%
	3,803	[illegible]	300	16	91.1%		
	2,206	1,799	222	27	76.2%		
	2,122						
	1,065						
nte	1,048						

Assigned PCP (12/14/21)	Total Members	Spanish Speakers	Spanish Speakers w/ Interpreter Needs Flag	% Spanish Speakers	% Spanish Speakers w/ Interpreter Needs Flag
Virginia Garcia MHC - McMinnville Clinic	6,283	982	402	15.6%	40.9%
Physicians Medical Center	5,797	827	231	14.3%	27.9%
PMG - Newberg Family Medicine	3,803	300	82	7.9%	27.3%
West Salem Clinic	2,206	155	20	7.0%	12.9%
VIRGINIA GARCIA MHC - NEWBERG CLINIC	2,122	292	94	13.8%	32.2%
West Hills Healthcare Clinic	1,065	79	26	7.4%	32.9%
Virginia Garcia MHC - Cornelius Wellness Center	1,048	222	74	21.2%	33.3%
A FAMILY HEALING CENTER - MCMINNVILLE	946	12	2	1.3%	16.7%

clinics that did not report a process for collecting or documenting accommodation needs. The YCCO team will prioritize those clinics with the most non-English speakers and those with gaps in their Accessibility Survey response for additional follow-up. Technical assistance follow-up will not be punitive but offer a model for educating clinics in language service requirements, reporting, and best practices, in an effort to increase rate of quality language service delivery.

Activities involved to address these areas are as follows:

- YCCO staff will work closely with clinics to support quality language access reporting and compliance with contract requirements. YCCO staff will conduct site visits to primary care clinics and forums for behavioral health staff to share the Language Access Toolkit, offer guides and support to use language services codes to document compliance with language service requirements and the language reporting requirements to YCCO.
- Using member language data and the results of the Provider accessibility survey, YCCO staff will also offer additional technical assistance to key clinics that have a higher density of non-English speaking patients or indicated in the survey that they need more support.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Widespread sharing of the Language Access Tool Kit through provider site visits, learning collaboratives, trainings, and individual technical support to improve member experience of care and support members in accessing and navigating the health system regardless of language or ability.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Track clinics receiving education or site visits and review changes in language access reporting, T and D code entry, and demonstrate quality improvement in 2023 Provider Accessibility Re-Survey.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Provider toolkit online and introduced to 10 providers.	Provider toolkit introduced to 12 primary care clinics and 30 behavioral health providers.	7/31/22	Provider toolkit one-pager posted in 50% of primary care clinics.	12/31/22

Activity 2 description: Targeted technical assistance to support provider workflows to identify language need, offer and request language services, and document the provision of language and culturally appropriate services.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Track clinics receiving technical assistance and review changes in language access reporting, T and D code entry, and improvement in 2023 Provider Accessibility Re-Survey.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Clinics have expressed uncertainty about language services, none have received TA	6 clinics receive personalized TA on offering and reporting language services	12/31/22	12 clinics receive personalized TA on offering and reporting language services	12/31/23

3 clinics used T codes in 2020	Increase in the use of T and D codes for documenting the use of a Certified/Qualified interpreter by 100%	6/1/22	12 clinics use T or D codes in encounters	12/31/22

A. **Project short title**: Project 177: Behavioral Health Neighborhood

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: **177**

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2: Serious and persistent mental illness
iii. Component 3: SHCN: Non-duals Medicaid
iv. Component 4: Utilization Review
v. Does this include aspects of health information technology? ☐ Yes ☒ No
vi. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vii. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Despite the challenges each Behavioral Health Neighborhood (BHN) clinic faced due to the COVID-19 pandemic in 2020 both continued to engage with their specific cohort of members (SPMI diagnosis). Although in person visits saw a 77% decrease, both clinics were still able to connect with many of their assigned members through telemedicine appointments to ensure continued primary care engagement. However, due to these in-person visit limitations, specific clinical quality measurements were far more difficult to collect and track. Since many of these identified members have more than one physical health comorbidity (diabetes, hypertension, etc.) it makes continued engagement with a primary care physician even more critical.

Along with the other data collected, clinics have begun to enter care plans on all members who have been identified in the program into The Collective Platform. Clinics are also creating cohorts of members within the platform to identify when this population goes to the ED. YCCO will initiate monitoring processes of this data for both clinics beginning in 2021.

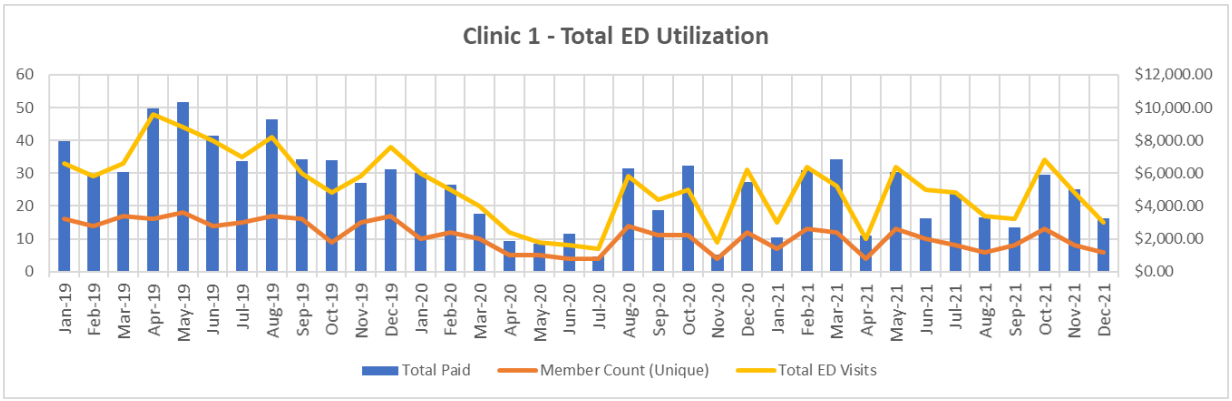
A licensed clinical psychiatric continued to provide consultation for both clinics to YCCO members as part of the BHC initiative.

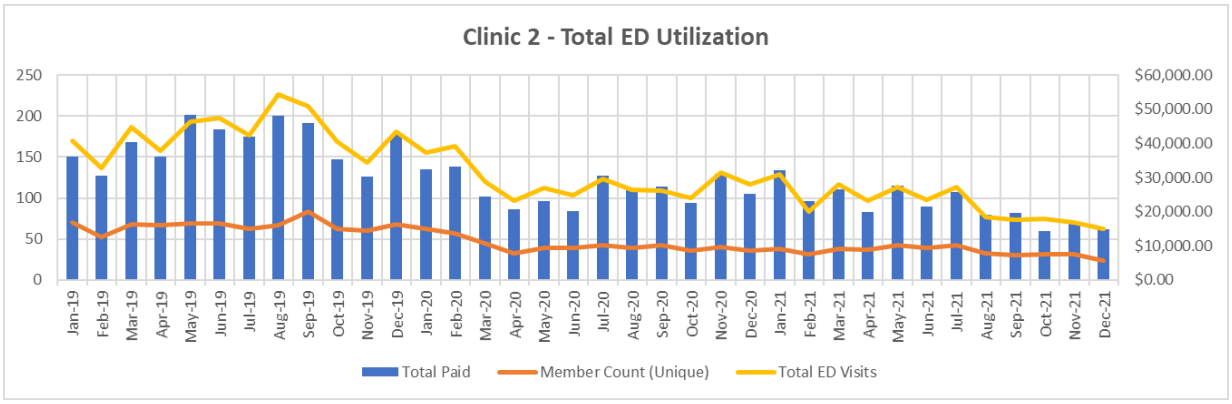
A 2021 goal of a 5-point reduction in mean PHQ-9 mean score of the cohort achieved just under a 1-point reduction during the year. This will be reported again at the culmination of 2022. Newly integrated member level data will allow tracking of health outcomes in a more meaningful way for 2022.

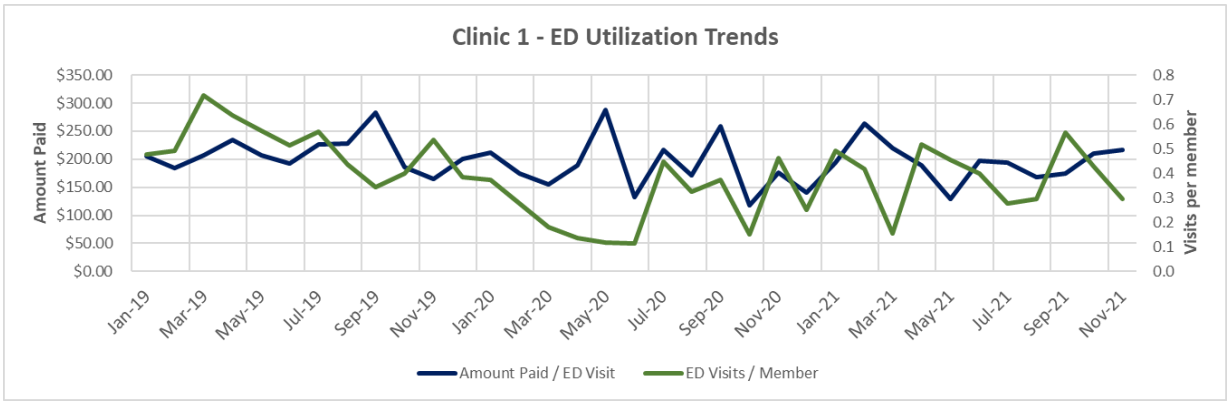
As seen in the charts below, costs of care were reduced over 2020 and 2021. This will continue to be tracked for 2022, while more closely integrating the health outcome data indicators. This will lead to the ability to develop a proper overview of the pilot project and recommendations for VBP integration and potential long term network upscaling.

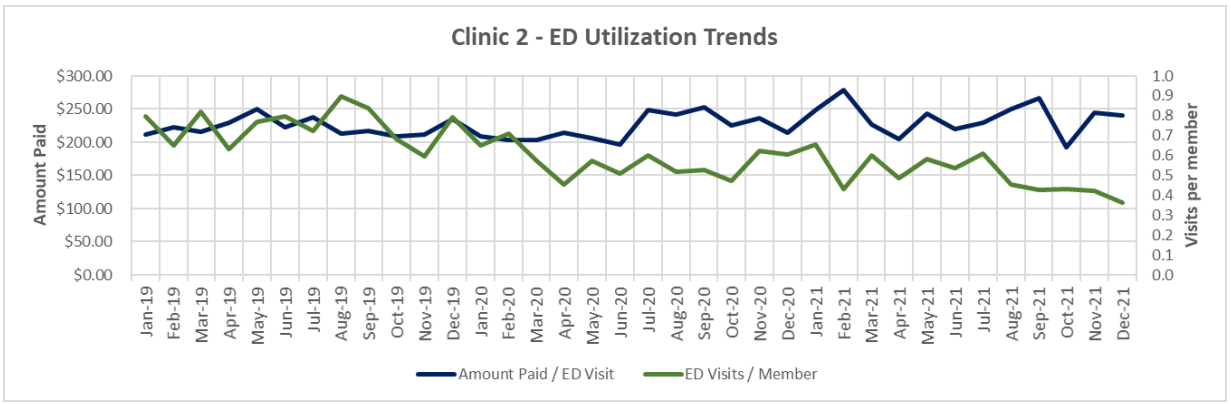
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

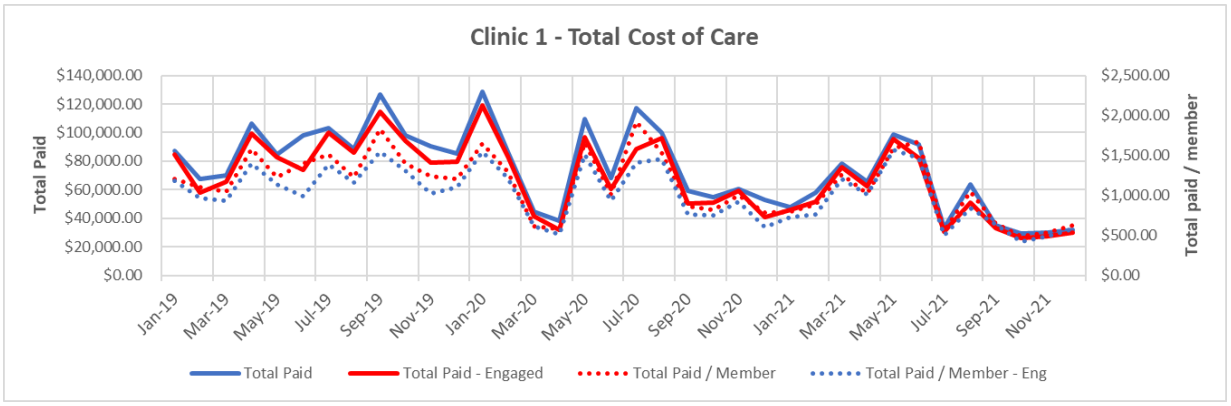
Both clinics saw decreases in emergency department utilization as well as total cost of care for their cohort of members over the course of 2020 and 2021 (see charts below). While these trends experienced the ebbs and flows of the pandemic, ED spend and overall total cost of care saw decreases. As this program stretches into 2022, YCCO will focus one final year on tracking member level health outcome data and utilization data, and will ultimately produce a final analysis report of the project, as well as a sustainability plan from a VBP standpoint.

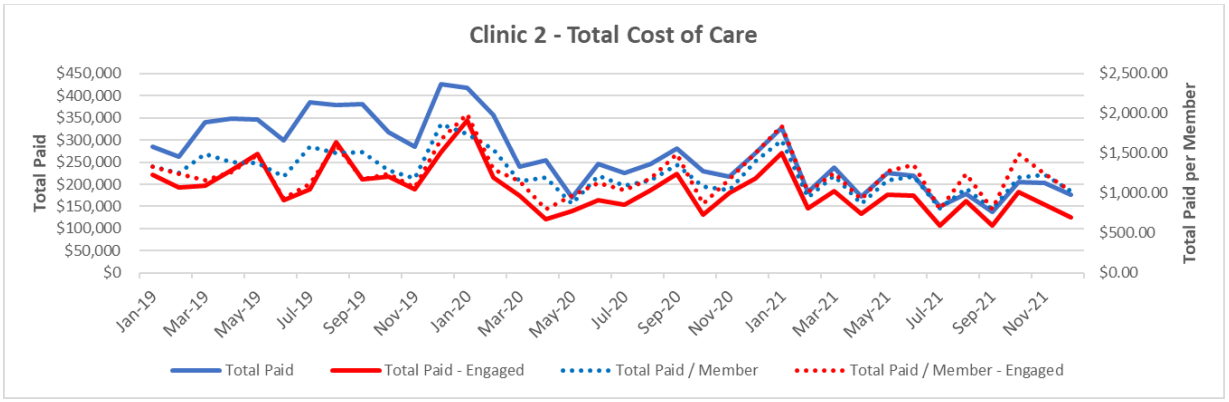












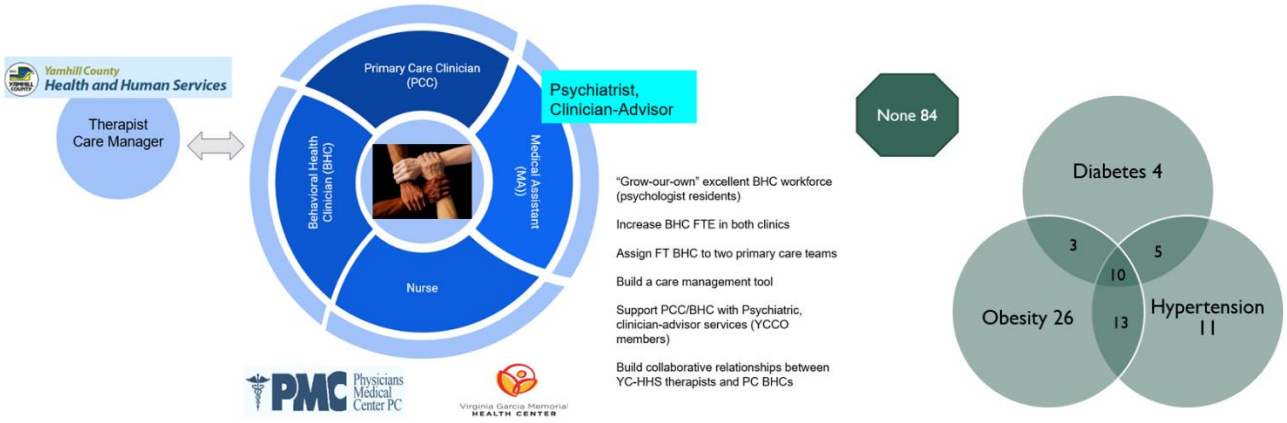
E. **Brief narrative description**:

High service utilizers (e.g. 5 ED visits/12 months, total cost of care > $1k/12 months etc.) constitute about 5% of YCCO patients yet consume 50% of overall costs. It is noted that a high percentage of these patients have mental health issues, substance abuse issues, or both. Many of these members also have other comorbidities such as diabetes, hypertension, and obesity. The social determinant of health (SDOH) of Health and Health Care is a determinant area that disproportionately impact individuals with behavioral health challenges. According to the World Health Organization (WHO) individuals with severe mental disorders have a 10-to-25-year life expectancy reduction and most of these deaths are due to chronic physical medical conditions such as

cardiovascular, respiratory and infectious diseases, diabetes and hypertension. One of the study clinics broke down the comorbidities of their members as demonstrated below. This will help inform all the needs of a particular member. By managing the behavioral health needs of a member, the hope is that the physical health conditions will improve as well. These components will be a part of the data collection process by the participating clinics in 2021.

Studies also show that those with SPMI are more likely to have difficulty navigating the healthcare system, so they misuse the Emergency Department more often that those who do not have a diagnosis of SPMI. This project aims to improve biopsychosocial primary care for all patients, with a coordinated and integrated model of care. Members being able to access Primary Care services as well as receive behavioral health supports allows for better access for members who otherwise would have to travel to multiple locations to receive care. The ability for the Primary Care Team to consult with a psychologist on medication management for members who are otherwise not able to readily access a behavioral health prescriber has been life changing for many of the members in the program. This is demonstrated in regular qualitative data that is collected from the participating clinics at quarterly meetings. Physician's Medical Center and Virginia Garcia McMinnville have entered into agreements to coordinate integrated care around patients, and track and share data with each other and YCCO.

Yamhill Community Care hired a subject matter expert to develop workflows that will better support those who have an SPMI diagnosis within two pilot clinics. YCCO supported these clinics to hire an additional behavioral health professional (either a LCSW or psychologist) to better support these members. YCCO also supports time for each clinic to consult with a psychiatrist to aid in evaluation and medication recommendations. There is also work within this group to increase use of The Collective Platform within this cohort of members. The clinics will be entering a care plan for each member they engage to let the ED doctors know they are enrolled in the program and any special considerations that should be considered while delivering care to the member while in the ED. Identifying these members in a cohort within the Collective Platform will also notify the care coordinator for the program at the PCP clinic that the member has been in the ED, so follow up care can be coordinated within 72 hours of discharge.



F. **Activities and monitoring for performance improvement**:

Activity 1 description: Staffing models are in place and member level data is being collected. This data will be reported to YCCO on a monthly basis for health outcome tracking. This will be aggregated and analyzed via a mid-year review and also at a 2022 cumulative level.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement : Clinics will continue to report monthly on the number of members that they have engaged in the Behavioral Health Neighborhood (BHN). They will continue collecting and reporting data on not only the progression of mental health condition markers such as PHQ-9 and GAD-7, but also on blood pressure, HbA1C and number of members in the cohort who have a BMI over 30. As members are engaged in the program to better support their behavioral health needs, the hope is that improvement in other health condition indicators will be observed. For 2022, member level data will be available for all cohort members for the entire year. This data will be utilized to determine success in these various health data outcome areas.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
This population has been increasingly engaged throughout 2021. This will be leveraged to track member level health outcomes in 2022.	Clinics will provide monthly member level data for health outcome tracking. YCCO will conduct mid-year and end-of-year health outcome tracking.	06/2022	40% of patients enrolled in the cohort will see reduction in weight, BP or HbA1C	03/2023

Activity 2 description : Create a sustainability plan. Currently this work is being seed funded by YCCO. The funding is being continued for another year due to COVID challenges. Now that the project work has begun, there is a need to create a sustainability plan to keep the work moving past the funding that is being provided by YCCO.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement : YCCO will collect ED and Inpatient stay data on the cohort from each clinic as well as total cost of care to show that the model is working. Clinics involved in the cohort will survey their providers on the program to evaluate for provider satisfaction and impacts on burnout in Primary Care. YCCO will track and evaluate preventative services sought by these members.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Greater than 10% reduction of total cost of care took	Goal for total cost of care to hold consistent OR decrease during	12/2022	Completed program evaluation and analysis (2020-2022) detailing cost	03/2023

place from 2020 to 2021.	2022 to show consistent positive impact of the program		savings, while pairing with health outcome data success indicators. Determination as to integration of these structures into long term VBP plans. Determination as to whether or not to upscale with other clinic partners.	

A. **Project short title**: Project 179: Infrastructure Development for the Tracking of Timely Access

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: **179**

B. **Components addressed**

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Note: This project has two separate components, 1) reassigning members to reduce driving distance to assigned PCP, and 2) access monitoring for primary care services. Each project is addressed individually in each section.

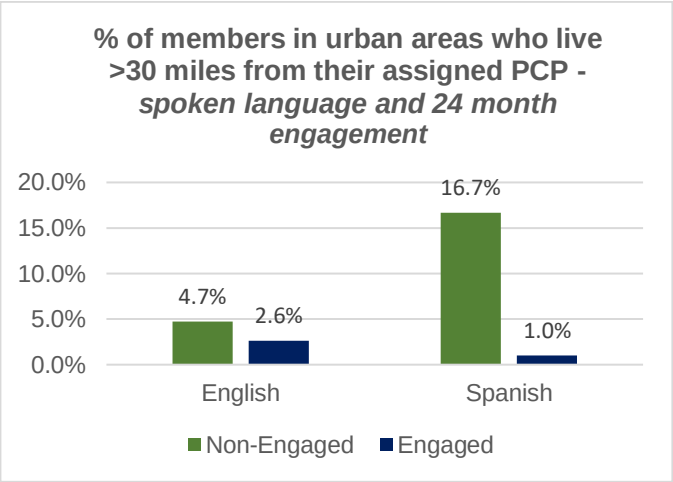
REASSIGNING MEMBERS TO REDUCE DRIVING DISTANCE TO ASSIGNED PCP

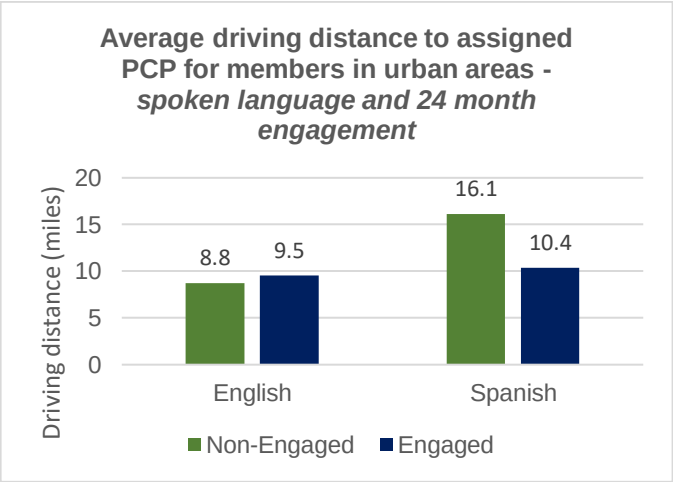
YCCO has identified notable differences in driving distance to assigned PCP among its members based on factors such as region of residence (urban/rural*), engagement in care**, race/ethnicity, and spoken language. A few notable examples as of December 2021 include:

- Among non-engaged members living in urban areas, English-speaking members lived an average of 7.3 miles closer to their assigned PCP than Spanish-speaking members (16.1 miles vs 8.8 miles)
- 16.7% of Spanish-speaking members in urban areas lived more than 30 miles away from their assigned PCP, while only 4.7% of English-speaking members lived more than 30 miles away from their assigned PCP.
- In nearly all cases, non-engaged members lived further away from their assigned PCP than engaged members. Most notably:
    - While 16.7% of Spanish-speaking members in urban areas lived more than 30 miles away from their assigned PCP, only 1.0% of Spanish speaking members did.
    - In rural areas, both English and Spanish speaking non-engaged members lived an average of two miles further away from their PCP than engaged member.

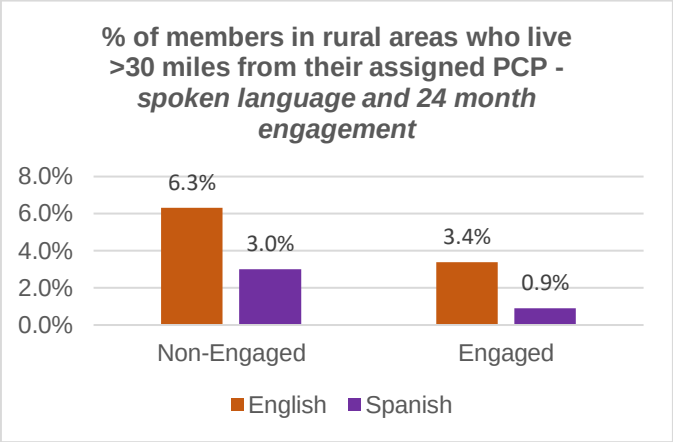
The primary goal of this project is to establish a dashboard to better quantify and understand the effects of a member's race, primary language, region of residence, and engagement status on their access to their assigned PCP. A secondary goal was to identify un-engaged members who live a significant time/distance (>30 miles estimated driving distance or >30 miles estimated driving time) from their assigned PCP as candidates for reassignment to a closer PCP to reduce these inequities and a potential increase in engagement with care.

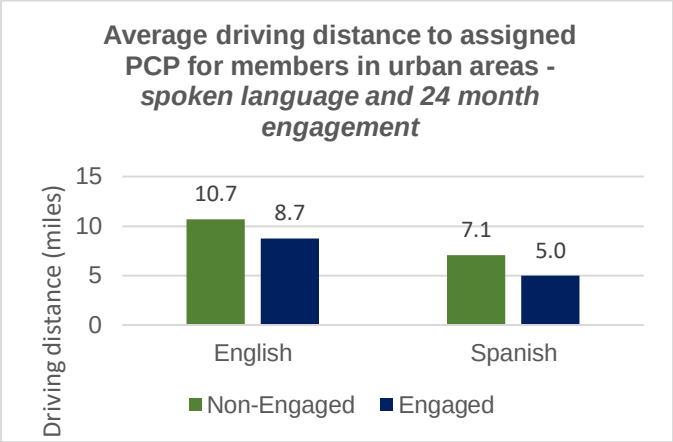
Members who reside in urban areas

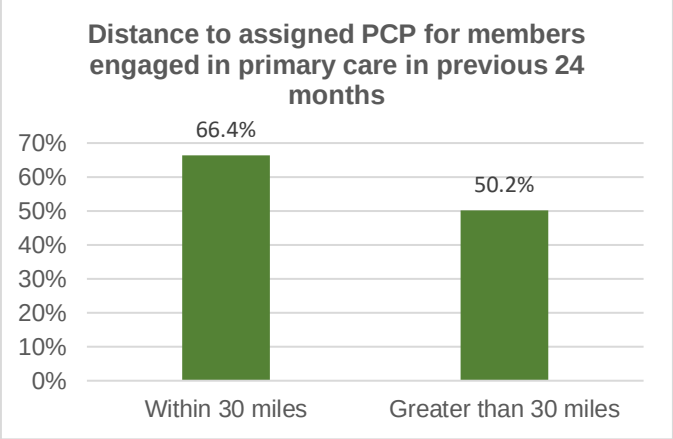


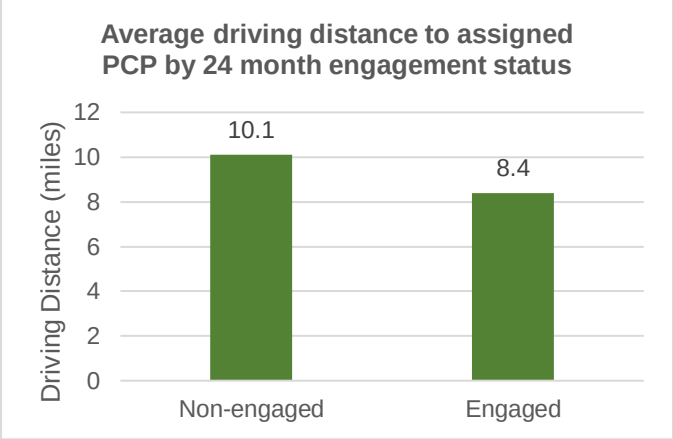


Members who reside in rural areas







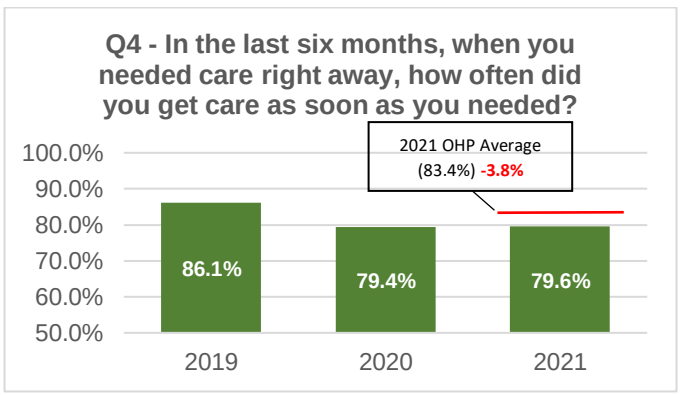


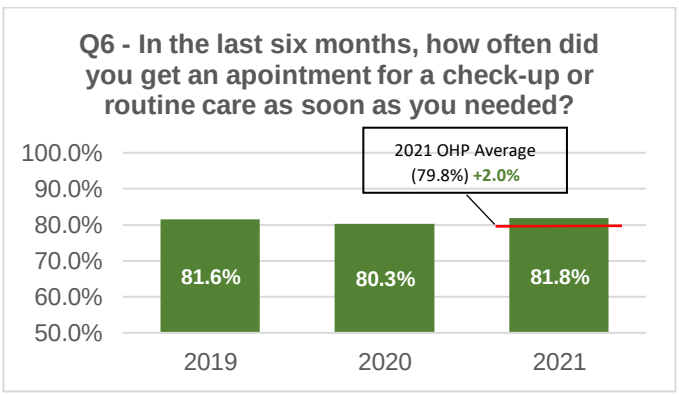
*urban/rural designation for members is derived from the monthly OHA Metrics Dashboard
** "Engaged" is defined as any primary care claim with assigned PCP in the previous 24 months.

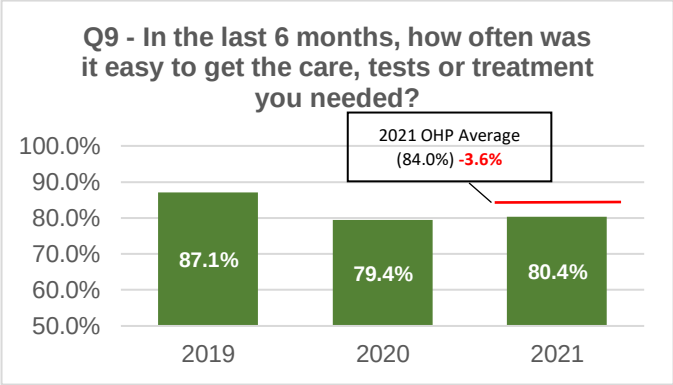
ACCESS MONITORING FOR PRIMARY CARE SERVICES

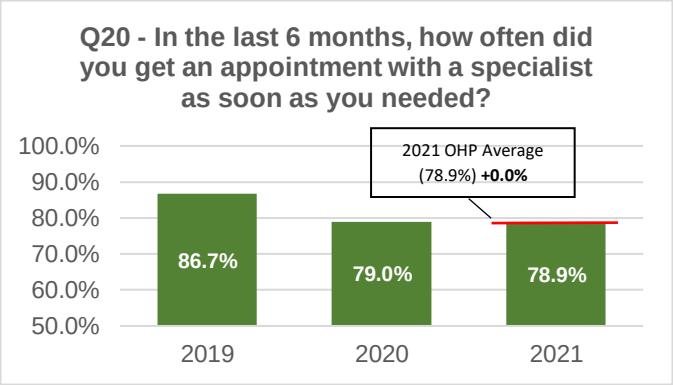
According to the results of the 2021 CAHPS 5.1H Medicaid Member Experience Survey, conducted between January and April 2021, YCCO receives mixed scores from its members in its ability to provide sufficient access to care. The annual CAHPS survey has four questions that refer to access to care. For these, while a majority of members answer "Always" or "Usually", YCCO's rates are at or below the average for OHP members for three of the four questions asked.

2021 CAHPS Survey Results (Access to Care)





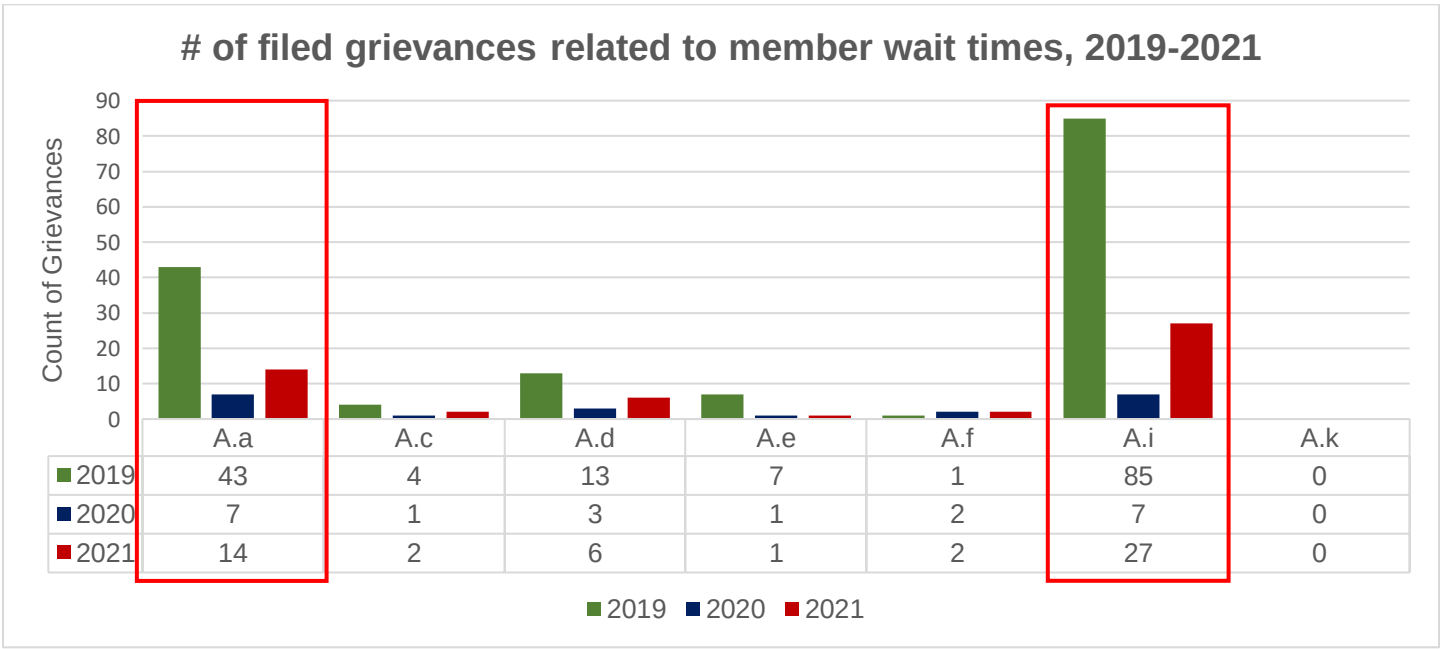




Results of 2021 CAHPS survey for questions pertaining to access to care. Percentages refer to the portion of members answering "Always" or "Usually".

Additionally, while grievances filed related to access to care dropped significantly in 2020, likely an effect of the COVID-19 pandemic, these began a return to previous levels in 2019. In particular, YCCO sees a significant number of grievances filed pertaining to category A.a (*Provider's office unresponsive, not available, difficult to contact for appointment or information*) and A.i (*Provider not available to give necessary care*). (see "*# of filed grievances related to member wait times, 2019-2021*" below).

Currently YCCO lacks a process for monitoring access to Primary Care services. Per OARs CCOs should be regularly monitoring access for both Primary Care and specialty services. Currently YCCO allows Primary Care Clinics to state how much capacity is available for members. Monitoring access for members in Primary Care especially, will ensure that the clinics we reassign members to will have proper access to services.



	A.a	A.c	A.d	A.e	A.f	A.i	A.k
2019	43	4	13	7	1	85	0
2020	7	1	3	1	2	7	0
2021	14	2	6	1	2	27	0

A.a) Provider's office unresponsive, not available, difficult to contact for appointment or information.
A.c) Provider's office too far away, not convenient
A.d) Unable to schedule appointment in a timely manner.
A.e) Unable to be seen in a timely manner for urgent/emergent care
A.f) Provider's office closed to new patients.

A.i) Provider not available to give necessary care
A.k) Female or male provider preferred, but not available

Initial data collected in February 2022 indicate that most clinics' access to urgent care and primary care are within OAR guidelines. However, **only 43% of clinics are meeting OAR guidelines for access to primary care for new patients.**

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

REASSIGNING MEMBERS TO REDUCE DRIVING DISTANCE TO ASSIGNED PCP

In 2020 a dashboard was developed to provide more granular and specific information about members who do not live within convenient driving time/distance from their assigned PCP, defined as >30 miles and/or 30 minutes for members living in rural areas, and >60 miles and/or 60 minutes for members living in rural areas. This dashboard combines information from the bi-weekly Member Engagement Report the most recent OHA dashboard, and the locations of YCCO's PCPs to generate a list of members who live furthest away from their assigned PCP. Users of the dashboard can filter based on race/ethnicity, primary language, 24-month engagement status, members in rural or urban areas, and whether the report will issue based on estimated driving distance or estimated driving time.* Integration of Special Health Care Needs status (SHCN) was included in Q1 2022.

	Est. Driving Time (minutes)	Member ID	Home Address	Home City	Assigned PCP
1	56.6			HILLSBORO	The Childrens Clinic - Portland
2	56.6			HILLSBORO	The Childrens Clinic - Portland
3	49.9			SHERWOOD	Providence Medical Group - Newberg
4	47.7			SHERWOOD	Providence Medical Group - Newberg
5	47.7			SHERWOOD	Providence Medical Group - Newberg
6	47.7			SHERWOOD	Providence Medical Group - Newberg
7	47.7			SHERWOOD	Providence Medical Group - Newberg
8	47.4			SALEM	Virginia Garcia MHC - McMinnville Clinic
9	43.9			SALEM	Virginia Garcia MHC - McMinnville Clinic
10	42.7			HILLSBORO	Hillsboro Pediatric
11	42.6			HILLSBORO	Hillsboro Pediatric
12	42.6			HILLSBORO	Hillsboro Pediatric
13	42.4			HILLSBORO	Hillsboro Pediatric
14	42.3			HILLSBORO	Hillsboro Pediatric

Parameters	
Language	SPANISH
Ethnicity	HISPANIC
Engagement Status	Y
Urban/Rural	Urban
Distance/Time	Time
Total members	106
Average Straight Line Distance to PCP (miles)	6.6
Est. Average Driving Distance to PCP	9.3
Est Average Driving time to PCP	18.6
# of Members > Maximum Driving Time	31
% of Members > Mamimum Driving Time	29.2%

Screenshot from dashboard (member ID and address redacted to preserve privacy of PHI)

**Estimated straight line distance* – *Calculated by applying the latitude and longitude of each member's home address and the latitude and longitude of each PCP's address to the haversine formula for calculating straight line distance between two points over the surface of the Earth (Distance = ACOS(COS(RADIANS(90-Lat1)) *COS(RADIANS(90-Lat2)) +SIN(RADIANS(90-Lat1)) *SIN(RADIANS(90-Lat2)) *COS(RADIANS(Long1-Long2))) *3958.75)*

Estimated driving distance – *Estimated straight line distance X 1.4*

Estimated driving time – *Assumes average driving speed of 29.8 mph → Estimated driving distance / (29.8/60)*

Given that YCCO's population is more linguistically and racially diverse in urban areas than in rural, addressing inequities in access to PCP has the potential to make a meaningful and quantifiable difference in quality of care for YCCO's members. In December 2021 1,974 members who lived in urban areas had not been engaged in care with their assigned PCP in the previous 24 months, an engagement rate of 50.0% vs. 70.0% for

members in rural areas. If a portion of these members could be reassigned to a new PCP closer to their home at the beginning of 2022, it would be possible to determine whether a closer assignment results in greater levels of engagement in care.

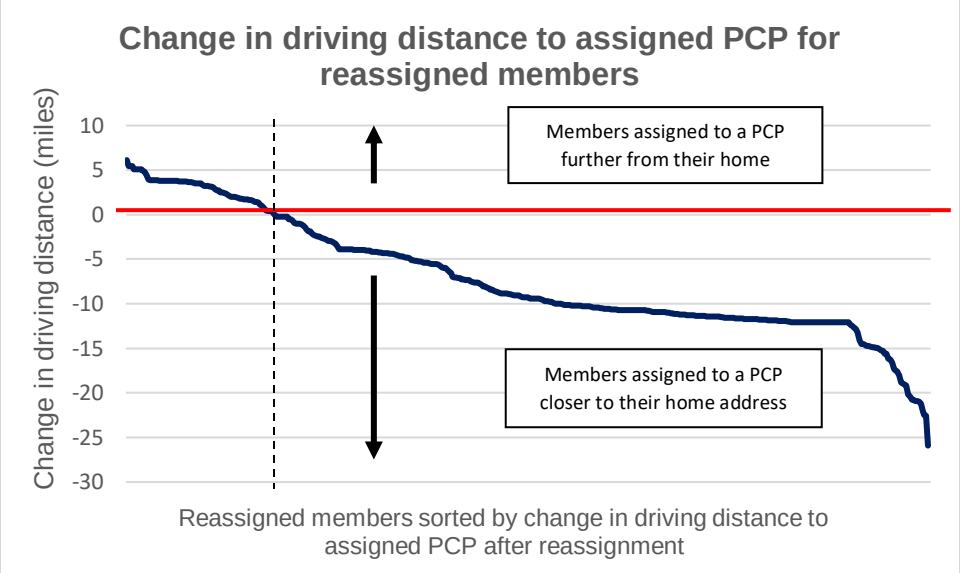
Methodology for member re-assignment:

Optimization add-ons for Excel exist which, for any given subset of members, can calculate the arrangement of PCP assignment that results in the shortest overall distance between members' addresses and location of their assigned PCPs. Repeated tests of this process as applied to PCP assignment have shown that it reliably and dramatically reduces overall driving distance to PCP for members. Note that reassignments factor in each given provider's current panel size, so that after applying the optimizer algorithm each provider still has the same number of members on their panel as they did originally.

After consideration of how best to apply this optimization algorithm to actual member PCP assignments, YCCO has determined that it would be best to use 2022 as a test year to identify any potential unforeseen resulting issues and to determine to what extent reassigning a member to a PCP closer to their home results in increased engagement in care. With that in mind, reassignments using the optimizer algorithm were determined in January 2022 according to the following criteria:

- **Limited to a single health care system:** In 2022, YCCO will only reassign members who are already assigned to a Virginia Garcia clinic to eliminate complications with enrolling a member in a different clinic network. YCCO is contracted with multiple Virginia Garcia clinics with a wide geographic distribution, making this still an effective test of this process.
- Only members with a minimum of 24 months enrollment with YCCO AND no PCP claims with their assigned PCP in the previous 24 months.
- Excludes members with a mental health claim with any VG clinic.

This resulted in 1,637 members, of which 446 were assigned to a different Virginia Garcia clinic. Of these, 81.6% were assigned to a PCP closer to their home, with a median net estimated driving distance of 10.5 miles and a maximum decrease of 25.9 estimated driving miles. For remaining members who were reassigned to a PCP further from their home, the median increase in distance was 3.5 miles and the maximum was 6.1 miles.



As a result of reassignment, a significant majority of reassigned members have been assigned to a clinic closer to their home, a majority of these more than 10 miles closer.

These reassignments were communicated to the Virginia Garcia system in February 2022, and are estimated to become effective at some point in March 2022. Care utilization for these 446 members will be tracked periodically over the course of 2022, with a final analysis made at the end of 2022 to determine whether reassignments resulted in a corresponding change in care utilization. It is also hoped that tracking and resolving any unforeseen issues that may arise will allow for greater expansion of this process to include more contracted clinics beginning in 2023.

ACCESS MONITORING FOR PRIMARY CARE SERVICES

In February 2022 YCCO initiated a process to monitor members' access to Primary Care. In Q2 this monitoring will expand to include specialty providers. YCCO will use both direct outreach to clinics as well as secret shoppers to obtain quantifiable and actionable data on the current state of access at these clinics. Once degree of access is determined, YCCO Provider Relations staff will have individual conversations with clinics to help them understand if they are in compliance with access standards and provide individualized support where necessary to improve access level.

E. **Brief narrative description**:

REASSIGNING MEMBERS TO REDUCE DRIVING DISTANCE TO ASSIGNED PCP

This project has three goals:

i. Determine whether changing a members' assigned PCP from one exceeding the time/distance standards for their area increases engagement in care.
   a) **To be achieved by** re-assigning non-engaged members enrolled in the Virginia Garcia system to other clinics within that system using the optimizer algorithm as described in

"Methodology of re-assignment" above at the beginning of 2022, and analyzing any resulting changes in care utilization for these members at the end of 2022.

ii. Reduce the discrepancy in estimated driving distance to assigned PCP between English-speaking members and Spanish-speaking members in urban area to less than five miles by the end of 2023.
   a) **To be achieved by** specially targeting Spanish-speaking members in PCP re-assignments beginning in 2023

iii. Reduce the percentage of all members in urban areas who meet the 30-minute estimated driving time benchmark by 25% by the end of 2023.
   a) **To be achieved by** regular monitoring of the impacts of re-assignments on the overall estimated driving distance to assigned PCP and adjusting as necessary.

ACCESS MONITORING FOR PRIMARY CARE SERVICES

The primary goal of this project is to create a structure to monitor access to ensure that all members have sufficient access to primary care services per OAR 410-141-3840, specifically ensuring that members have access for urgent issues within 72 hours, well care within four weeks, and primary for new members within four weeks. This will be accomplished through direct provider outreach and the use of secret shoppers to determine the current state of access, and by providing clinics with individualized support to bring them into compliance where necessary.

F. **Activities and monitoring for performance improvement**:

REASSIGNING MEMBERS TO REDUCE DRIVING DISTANCE TO ASSIGNED PCP

Activity 1 description: Identify causal effects of distance to assigned PCP on engagement rate.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Causal impacts of distance to assigned PCP on engagement rate unknown.	Initial assessment of causal impacts of distance to assigned PCP on engagement rate.	12/2022	Causal impacts of distance to assigned PCP on engagement rate known within 95% confidence interval	12/2023

Activity 2 description: Reduce the discrepancy in estimated driving time to assigned PCP between English-speaking Caucasian members, English-speaking Hispanic members, and Spanish-speaking Hispanic members to less than five minutes through re-assignment of unengaged members to PCPs closer to their home address.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Estimated driving distance to assigned PCP for English-speaking members is 7.3 miles less than for Spanish-speaking members.	Reduce this discrepancy to five miles or fewer	12/2022	No significant race/ethnicity or linguistic discrepancies in PCP access.	12/2025

Activity 3 description: Increase the percentage of all members in urban areas who meet the 30-mile estimated driving time benchmark by 10%.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of December 2021, 671 members in urban areas exceed the 30-minute estimated drive time standard.	Reduce the portion of members in urban areas who live greater than 30 estimated driving minutes from their assigned PCP by 25% (168 members by December 2021 enrollment).	12/2023	Fewer than 10% of members in urban areas exceeding 30 estimated driving minutes from assigned PCP.	12/2025

ACCESS MONITORING FOR PRIMARY CARE SERVICES

Activity 4 description: Increase YCCO's capacity to monitor Physical Health access for members. Provide feedback to clinics on access standards.

☒ Short term or ☒ Long term

Monitoring activity 4 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current monitoring (as of January 2021)	Monitor Primary Care Access quarterly in 2022.	12/31/2022	80% of PCP clinics meeting OAR access standards for new patients.	12/2023

Only 43% of PCP clinics meeting OAR access standards for new patients.	Monitor access for Specialty services. Provide feedback to clinics on access standards, and compliance.			

A. **Project short title**: Project 407: Supporting Members Who Experience System Barriers

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

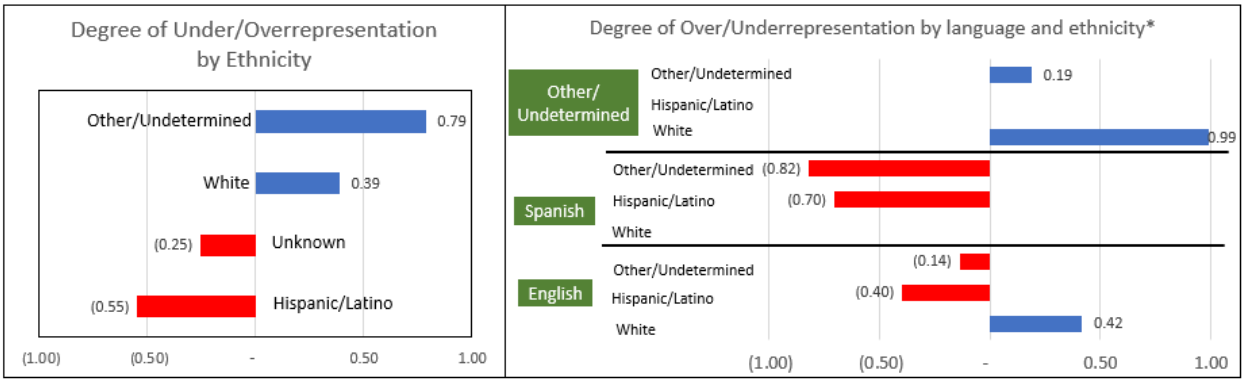
If continued, insert unique project ID from OHA: 407

B. **Components addressed**

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Access: Cultural considerations
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☒ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? 14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

CCOs are required under Federal and State rules to provide culturally and linguistically appropriate services to members at no charge. While these requirements are written and implemented in a variety of policies, procedures, handbooks and contractual agreements, the quality and consistency of the delivery of these services is partially unknown. Grievance and customer service data does not indicate significant reported barriers in these areas. Numbers of grievances overall were low, especially for non-English speakers, and grievances and complaints related to language services were made only by English speakers.



The 2021 project assessment of grievance data related to cultural or language barriers was analyzed and showed no usable trends. Data shows that very few grievances are reported for interaction with plan or provider (IP) category. Only nine complaints have been filed over the past 6 years of data collection.

Deeper case review revealed that the types of grievances filed were complaints about miscommunications with the plan or provider related to referrals, call routing within customer service, or unfair treatment associated with their identity i.e., LGBTQ parents, a black patient whose provider assumed had a different race and language needs and initiated care speaking in Spanish. Three of the nine grievances referenced reverse discrimination related to perception of identity, Spanish language spoken when not the Members' primary language, or a negative experience with the delivery of care related to opioid prescribing/pain management related to their identity. All of these grievances were filed by members who identify as Caucasian and who speak English as their primary language.

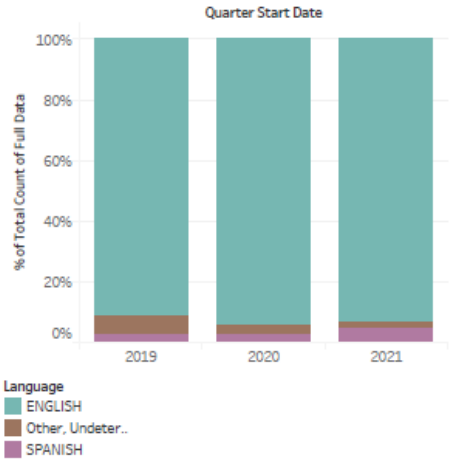
Count of Grievance Type									
Row Labels	1/1/2016	4/1/2016	10/1/2016	4/1/2017	4/1/2019	10/1/2019	4/1/2020	Grand Total	
IP.h			2			1		3	Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.
IP.i	1							1	Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity.
IP.j		1		1	2		1	5	Member has difficulty understanding provider due to language or cultural barriers.
Grand Total	1	1	2	1	2	1	1	9	

YCCO language access data shows a series of limitations, from the breadth of information available from partner clinics to the information available from member grievances and vendor reports. This has revealed a need to not only enhance data collection and analytics processes, but also to better educate members on providing feedback and understanding their rights. This project will enhance data systems regarding members' access to services and offer education to improve reporting and grievance pathways from internal staff, partners, and members alike.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Grievance data reveals that a disproportionately low rate of non-English speaking members file complaints or appeals. This number hints that those needing language services do not have access to information or support needed to file complaints or appeals successfully. It appears that the current system YCCO will, in this project, develop mechanisms to better understand barriers through existing service data and collect more feedback from non-English speaking members, especially those who have received language services, to understand their experience. YCCO will also disburse plain-language member education materials to support this information-sharing.

	Language Ud (group)		
Year of Quarter Sta..	ENGLISH	SPANISH	Other, Undetermined
2021	92.6%	5.3%	2.1%
2020	94.0%	3.4%	2.6%
2019	93.4%	2.9%	3.6%



While there are clear language access requirements, provider ability to document these services and YCCO's ability to monitor them has historically been limited. Awareness of these documentation processes is limited even among YCCO staff, per a 2021 internal workgroup review. To best improve quality of care for members, YCCO must first understand the provision of these services and address gaps. Because there isn't available grievance data, YCCO must explore potential gaps with the data available.

YCCO has identified which clinics have the highest rate of non-English speakers, and will prioritize those in technical assistance and outreach, to ensure members needing interpretation services are receiving the most appropriate care. The table below shows which Spanish speakers have an interpreter needs flag; YCCO will use this to review which patients needing interpretation actually received it in the clinic. For those who did not, while this is not a grievance filed by a member, it does present a barrier that may warrant one.

Assigned PCP (12/14/21)	Total Members	Spanish Speakers	Spanish Speakers w/ Interpreter Needs Flag	% Spanish Speakers	% Spanish Speakers w/ Interpreter Needs Flag
[redacted]	6,283	982	402	15.6%	40.9%
	5,797	827	231	14.3%	27.9%
	3,803	300	82	7.9%	27.3%
	2,206	155	20	7.0%	12.9%
	2,122	292	94	13.8%	32.2%
	1,065	79	26	7.4%	32.9%
	1,048	222	74	21.2%	33.3%
	946	12	2	1.3%	16.7%
	898	52	22	5.8%	42.3%

Based on review of the comprehensive Accessibility Survey fielded with physical, behavioral, and oral health providers, 36 clinics were identified as needing extra support based on at least one answer, with 4 clinics responding to multiple questions with answers that warranted follow-up. These ranged from clinics reporting that they use volunteers to provide language assistance clinics to clinics that did not report a process for collecting or documenting accommodation needs. Reporting of the use of interpretation services is severely limited, with only a handful of clinics using the proper codes. While these codes aren't reimbursable, they are vital to understanding compliance.

Billing Provider Name	2019	2021
[redacted]		6
	3	
		1

In technical assistance to providers, YCCO will work to understand barriers to reporting this information. Past discussions have revealed that billing a non-payable code can delay processing for clinics, and YCCO will conduct troubleshooting internally to ensure this reporting is low-barrier for clinics and staff. This reporting will be used alongside with language flag, language access data from language service vendors, and any new grievances that are filed, to best understand true member barriers in the area of language access.

These interventions and assessments will improve operational processes to determine how language access specifically may be a barrier to members, whether lack of language services is limiting complaints or appeals being filed, and assess actual experience with language services in order to develop a member-friendly complaint and appeal process for those who need language assistance.

E. **Brief narrative description**:

This project will address issues members who need language services many encounter, and monitor and improve these barriers according to identified need. Activities in this project are as follows:

1) YCCO will develop processes for integrating language needs into its existing reporting and analysis to better understand gaps and barriers in member services. This will include working closely with language vendors to improve and streamline reporting processes, with existing data sources like grievances and appeals to understand disparities, and with clinics to improve reporting capacity and compliance with language services requirements.
2) YCCO will conduct provider and member outreach and education around language services. Members will receive plain language information about their rights regarding language services, how to request these services, and how to complain about not receiving them in a quality or timely manner. YCCO will also develop mechanisms to gather feedback from non-English speaking members and more effectively monitor experience of service.
3) Internal staff will receive comprehensive training on member rights regarding language access. Those who have direct member contact will also receive specialized training on how to recognize and document complaints or grievances appropriately.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Further integrate language access data and collection into YCCO quarterly monitoring and reporting to understand Member barriers for accessing/receiving language support. Develop reporting systems within language vendors and clinics to evaluate language service delivery and identify potential gaps and barriers.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Improve data collection and analysis processes to better identify barriers.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1,108 Spanish speakers at the top ten highest enrollment clinics have an interpreter flag associated with their file. The number of those with an interpreter flag who *are* receiving language services in the clinic is unknown.	Both vendors and clinics report which members receive language services.	12/31/22	50% of patients with a language flag who received language services at an appointment are reported through language vendors or clinics.	12/31/23
3 clinics used T codes in 2020	Increase in the use of T and D codes for documenting the use of a Certified/Qualified interpreter by 100%	6/1/22	12 clinics use T or D codes in encounters	12/31/22
1 contracted language vendor can report member-level service delivery to YCCO	2 contracted language vendors (100%) can deliver and report member-	6/1/22	2 contracted vendors send regular detailed reports to YCCO	12/31/22

	level service delivery to YCCO members			

Activity 2 description: Member education and resources for how to request and work with a language service provider and report when barriers arise. Develop a member-facing language access toolkit, modeled after the provider toolkit. Share out with members through digital and in-person methods.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: YCCO Member Barriers Subcommittee (CAC representatives) will support development of member education toolkit and other resources. YCCO CHW staff trained in identifying grievances will log them appropriately. YCCO staff will develop and disburse member survey for those who have received/who need language services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Members receive general language access rights and information through the handbook and YCCO website.	Members receive specific language access rights and information through multiple CAC-reviewed modes, including direct information sharing through CHW Hub.	12/31/22	Members report increased knowledge of language access rights in 2023 survey	12/31/23
0 language related barriers have been reported from non-English speakers.	10 members who have received language services provide feedback through surveys or CHW outreach.	12/31/22	20 members who have received languages services provide feedback through surveys or CHW outreach.	12/31/23

Activity 3 description: Offer training to staff who perform member touch services (Customer Service, Care Management, Community Health Hub, Health Services) on how to support members in accessing culturally specific care and how to document when barriers are experienced through the grievance and appeals system

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Training and attendees are documented; attendees complete post-training survey.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
All YCCO staff receive CLAS training annually.	100% of YCCO staff receive mandatory language access and member rights training.	6/1/22	100% of YCCO staff receive comprehensive language access training annually.	6/1/23
Member-facing staff receiving no specialized LA training.	100% of member facing YCCO staff receive specialized language access and grievance reporting training.	6/1/22	100% of member facing YCCO staff receive specialized language access and grievance reporting training annually.	6/1/23

A. **Project short title**: New Project: Integrated Oral Health Services for Pregnant or Diabetic Patients

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project

If continued, insert unique project ID from OHA: new

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The Yamhill Oral Health Coalition has been a guiding force in YCCO oral health integration projects, supporting integrated Community Connect events with integrated dental care, an oral health community assessment, and continuing education events.

In previous Oral Health Integration TQS projects, YCCO has prioritized building relationships and referral pathways between providers of different disciplines. A series of successful meet-and-greet and Continuing Medical Education events have built connections between oral health providers and other physical and behavioral health providers and systems. Oral health providers have received education on how to refer to other disciplines, and vice versa. In the last year, it has become apparent that additional oral health supports have been needed, as dental care overall dropped during the pandemic, a high risk for many populations.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

The Oral Health Coalition specifically identified infants and families as priority populations that needed to be connected to services. Additionally, YCCO identified members with diabetes as another high-risk category needing additional support. Pregnant people can experience birth risks like premature delivery, pre-eclampsia, and low birth weight babies as well as dental concerns like dental erosion and gingivitis. Because of perceptions of danger in dental care during pregnancy, some people avoid the dentist while pregnant. Gingivitis has been found in 40% of pregnancies (*Silk H, Douglass AB, Douglass JM, Silk L. Am Fam Physician. 2008 Apr 15; 77(8):1139-44.*). Forty-eight percent of pregnant people who were contacted by a YCCO CHW in 2021 did not have a dentist.

Periodontitis can be a common co-occurrence with diabetes, and periondontitis, cavities, and limited tooth brushing can all be associated with larger risks like cardiovascular disease (*Song T, Jeon J, Kim J. Cardiovascular risks of periodontitis and oral hygiene indicators in patients with diabetes mellitus. Diabetes & Metabolism. 47(6). 2021.*). Only a third of YCCO members with diabetes accessed any kind of dental care in 2020.

In the past few years, outside of TQS projects, Capitol Dental Care has developed systems to hold available appointment slots for certain urgent cases and priority populations, including those with diabetes diagnoses. However, dental utilization for diabetics has decreased in 2020.

Diabetes

Year	Total Diabetic Members	Members with a dental visit	%
2019	857	362	42.2%
2020	1223	408	33.4%

The number of pregnant people receiving dental care in 2021 was also concerningly low, at only 23%.

Year	Total Pregnant Members	Members with a dental visit	%
2021	408	97	23.8%

Anecdotal evidence from the local Oral Health Coalition and Quality and Clinical Advisory Panel shows that not all providers are familiar with processes to refer patients into dental care, and Community Advisory Council feedback indicates that members are unaware as well. Perceptions of overall dental availability are that it is extremely limited locally. The goals of this project are to increase referral into dental benefits and services for providers to increase utilization for these two target populations, as well as ensure comprehensive, whole-self care for these individuals, from physical, behavioral, and oral health to social wellness.

E. **Brief narrative description**:

This project includes two main activities:

- development of data-sharing process to ensure appointment adequacy for priority populations, and continued provider education on importance of dental care referral
- internal THW workflow to support referral of pregnant patients to dental care

The goal of the project is to increase the rate of patients with those diagnoses who access dental care in the project period. This data will be stratified by location and language, to better understand disparities related to these populations. Over the course of the project, YCCO anticipates also exploring how non-clinical providers can use CIE to refer YCCO members into dental care.

Currently, Capitol Dental attempts to keep available appointments for urgent needs and patients who are identified as being pregnant or diabetic. However, YCCO does not have a process to ensure these appointments are adequate to meet the needs of every pregnant or diabetic member. YCCO will work closely with Capitol to share updated member information related to these conditions, and confirm with Capitol that an appropriate and timely number of appointment slots are available.

Currently, YCCO performs outreach call to every YCCO member who has been identified as pregnant. These outreach calls are designed to ensure members are aware of and connected to the appropriate services, including health appointments, WIC, doulas, and other social supports. However, currently the THW staff conducting these calls can only provide Capitol Dental's Customer Service number and direct the member to reach out. In this process improvement, project, YCCO staff will be able to send referral lists of members who have indicated they do not have a primary care dentist, and Capitol will perform outreach to get the member a timely appointment. In 2021, 225 pregnant YCCO

members were identified and contacted. 57% of these calls were successful in reaching the member. Of those calls, YCCO found the following:

Number of members	Category of dental care for member
10	CCOB, no dental benefit
47	have a dentist
62	didn't have a dentist, were given number to call
9	member did not provide information

Of those contacted (who answered their phones), 27/98 (27.6%) had a dental visit. For those who did not answer their phones, 24/92 (26.1%) had a dental visit, indicating that informing people they have dental coverage does not seem to have much impact on dental engagement. These activities will attempt to improve the effectiveness of this outreach.

Finally, YCCO will partner with clinics and CBOs to ensure awareness of referral processes into Capitol Dental for YCCO members. These activities will be completed in clinic site visits and provider newsletters. CBO outreach will occur through Service Integration Teams and direct outreach with local Traditional Health Workers like doulas and Community Health Workers.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Conduct site visits and multi-modal outreach to physical and behavioral health providers to educate them about the importance of and process for referring pregnant and diabetic patients to oral health care. Coordinate with Capitol Dental Care to share member data to ensure appropriate number of open dental appointment slots for patients with diabetes and pregnant patients; coordinate referral for highest risk members as appropriate.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Improve rates of specific member populations accessing dental care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Rate of diabetic patients who have accessed dental care in 2019: 42.2% 2020: 33.4%	47%	12/31/2022	50%	12/31/2023
Monitoring measure 1.2	Ensure adequacy of dental service available for diabetic or pregnant YCCO members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Number of available dental appt. slots for diabetic patients: unknown/~1223 Number of available slots for pregnant patients: unknown/~225	50% of identified diabetic and 70% of pregnant patients have an open dental appt slot available within three weeks	12/31/2022	70% of identified diabetic and 100% of pregnant patients have an open dental appt slot available within three weeks	12/31/2023

Activity 2 description: Utilize pregnancy outreach calls through the YCCO Community Health Hub, connecting newly pregnant members to Capitol Dental to make appointments.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor effectiveness of maternity outreach calls and direct referral to care.

Monitoring measure 2.1	Utilization rate tracking of specified population.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Rate of pregnant patients who accessed dental care in 2021: 23.3%	70%	12/31/2022	75%	12/31/2023
Monitoring measure 2.2	Tracking of referrals made to the specified population.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0/62 pregnant people who did not identify a dentist were referred directly to Capitol Dental to make an appointment	100% of pregnant members who do not have a PCD are referred to Capitol Dental	12/31/2022	30% are referred to dental care and secure appointment	12/31/2023

A. **Project short title**: New Project: PCPCH Tier Advancement and Member Enrollment Improvement

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project

If continued, insert unique project ID from OHA: Add text here

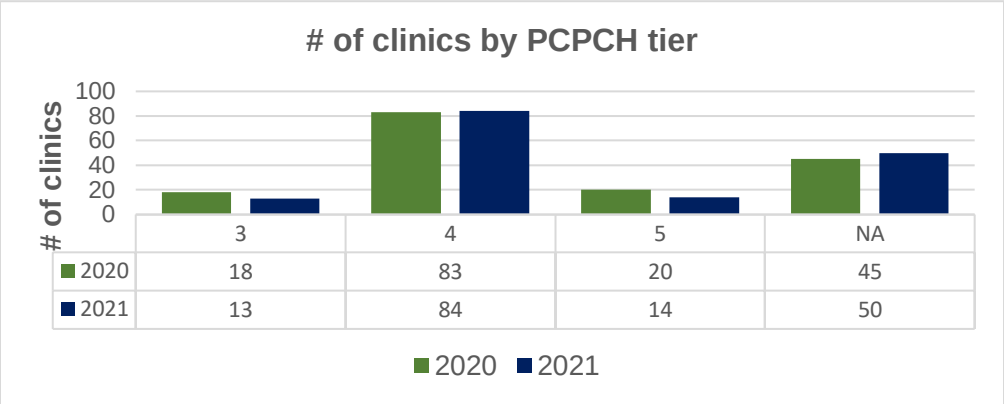
B. **Components addressed**

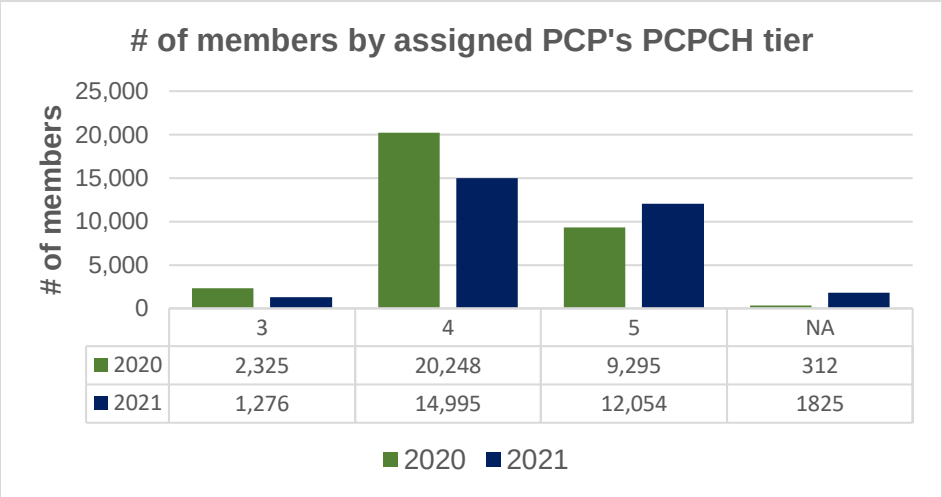
i. Component 1: PCPCH: Member enrollment
ii. Component 2 (if applicable): PCPCH: Tier advancement
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

YCCO currently has a positive trend of increasing numbers of clinics with PCPCH enrollment as well as members who are assigned to these clinics. In 2020 YCCO had 45 clinics with PCPCH recognition, and in 2021 we had 50 clinics who had recognition. YCCO had 12 clinics in 2020 who had received tier 5 recognition, and in 2021, despite a pandemic, that number rose to 20. In 2022 YCCO would like to continue this trend both in the number of clinics recognized as well as increasing clinics to a higher tier. YCCO also has policies that only allow for new members to only be assigned to clinics who have achieved PCPCH recognition. YCCO had an APM payment structure that promotes clinics to achieve a higher

tier status as well as technical assistance from YCCO on how to achieve these goals.





YCCO's APM clinics experienced a decline in PCPCH status among 12 PCPCH clinics. Many of the issues were related to staffing issues. Some of these clinics have let their PCPCH status expire altogether, as they did not have the staff capacity to renew their application. Some of YCCO's PCP clinics that opened just prior to COVID, or even during the pandemic have not have the staffing resources to devote to standing up a PCPCH program at their clinic. Some clinics have also decided to reapply at a lower tier status, as staffing limitations and pandemic stressors, have not allowed the clinic to support certain activities.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians. YCCO currently uses PCPCH in a variety of ways to assess a clinics ability to provide quality care to its members. YCCO also incentivizes clinics financially to promote becoming PCPCH certified, as well as to increase tier advancement within PCP clinics. YCCO is committed to providing support to clinics to achieve these goals in 2022.

Brief narrative description:

- Provide monthly collaborative for Primary Care Clinics with a focus on PCPCH components
- Explore interest in PCPCH specific collaborative for clinics working on advancement
- Provide one on one TA to target clinics to support them in Tier advancement or initial recognition
- Provide bi-annual site visit where individual needs are addressed and supports needed are identified
- APM methodologies that support clinics financially for Tier advancement
- Auto Assignment of new members to only PCPCH recognized clinics
- APM add on payments for PHPCH recognition based on tier status

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Identify and outreach to clinics without a PCPCH designation and offer TA to guide clinics to Tier 3 or higher recognition status.

☒ Short term or ☒ Long term

Monitoring measure 1.1	Number of clinics who advanced in tier status in 2022			
Baseline or current state		**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current Clinics in our network with no PCPCH Recognition	Provide TA to two currently unrecognized clinics to achieve a tier 3 or higher recognition.	12/31/2022	All PCP clinics in local service area with PCPCH recognition	2024
Monitoring measure 1.2	PCPCH tracking			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Provide TA to clinics to achieve tier advancement	Clinics advance in Tier status	June 2023	50% of APM clinics with tier 5 recognition	2024

Activity 2 description: YCCO will provide TA to clinics within the network that have lost tier status due to COVID to regain their pre pandemic recognition level.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: YCCO will engage with clinics to assist them in achieving pre-pandemic recognition status.

Monitoring measure 2.1	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently we have 12 clinics who have dropped a Tier level due to COVID	Provide TA to clinics to help them regain tier status	6/2023	All clinics to regain pre-pandemic level recognition	2024

	Clinics achieve higher level based on clinic goals			

A. **Project short title**: MEPP Episode 1: Case Management Efficacy for Members with Diabetes

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: N/A

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable):
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Prior Year Intervention Assessment:

Intervention 1: YCCO completed an analysis and identified currently enrolled members with a diagnosis of diabetes and costs associated with treatment of the chronic condition.

Intervention 2: Based on the identified members, YCCO implemented a workflow to engage these members with care programs and primary care providers.

The workflow includes a weekly referral process for newly enrolled/transitioned members or those recently diagnosed. The process includes member assessment for care coordination or intensive care coordination programs. These referrals accessed community health workers or registered nurse case managers to support member's engagement with primary care, identification of specialty referral needs and educate members on disease and medication management.

Intervention 3: YCCO was able to accurately identify based on PAC data and strengthen case management outreach for these members. Utilizing a risk score, YCCO can quickly engage members who would most significantly benefit from health coordination and case management. Referrals are made to care coordination programs and PCPs are notified of enrollment and provided the case management plan of care when applicable.

Intervention 4: Currently these referrals and workflows are being evaluated to calculate engagement and track trends over time. This will allow YCCO to identify and remove any barriers that might decrease member participation and follow up with more frequent HbA1c testing. YCCO will also evaluate claims data on HbA1c labs to identify clinics/providers that might require additional outreach and support to increasing member's engagement and timely testing.

Care management program resources originally included in the opportunity required routing to COVID 19 outreach for positive cases, post hospitalization follow up and care coordination support with telehealth improvements.

YCCO discovered this need in February 2020 as a result of the nationwide pandemic. This population wide risk continued throughout the rest of calendar year 2020. While the focus around the Diabetes episode remained a constant review item for YCCO, the capture of these cases were driven by acute ER and inpatient stay for high risk members rather than the chronic disease population as a whole.

YCCO's Member Engagement Hub and Care Management teams worked closely with providers and community partners to:

- identify members with acute diabetic ketoacidosis,

- inpatient confinements due to their chronic diabetes mellitus, and

- monitored DHS long term care and support needs for these members that were referred to our Multidisciplinary Team (MDT) meetings monthly.

Tactics used for these sources were:

- provider referrals,

- Collective Medical's disease specific and ED utilization cohorts,

- education to school districts around Wellness to Learn program for early intervention,

- screening assessments for diabetes related encounters with outreach calls from care coordination technicians.

By narrowing the review process, it allowed YCCO and partners to engage the members with the highest needs in this specific diagnosis group.

YCCO took the goal of more frequent HbA1c testing and primary care engagement into 2021 to further expand the care coordination and targeted approach to support the (471) currently enrolled members identified with Diabetes related PAC.

The baselining activity below shows how claim and cost trends presented for 2020 vs 2021 data. This data review will happen after 2022 claims runout to show how increased Care Management structures and focus for this population drive Inpatient and ED claims trends.

This intervention has met the goals of the action plan. The remaining work referred to in the Dashboard deliverable has been achieved through the hiring of an additional internal Health Services Specialist, which has allowed for increased provider training and support for high-risk members, as well as additional development work for connecting high-risk members with ICC services.

While not entirely based on the structural work within the MEPP project, the impacts of these changes are reflected in the charts below, showing Care Management engagement rates and inpatient readmission rates:

Engagement Rates

Case Management Engagement Rate Comparison Year over Year
Each category represents unique members. Note that members can participate in more than one type of Care Management.

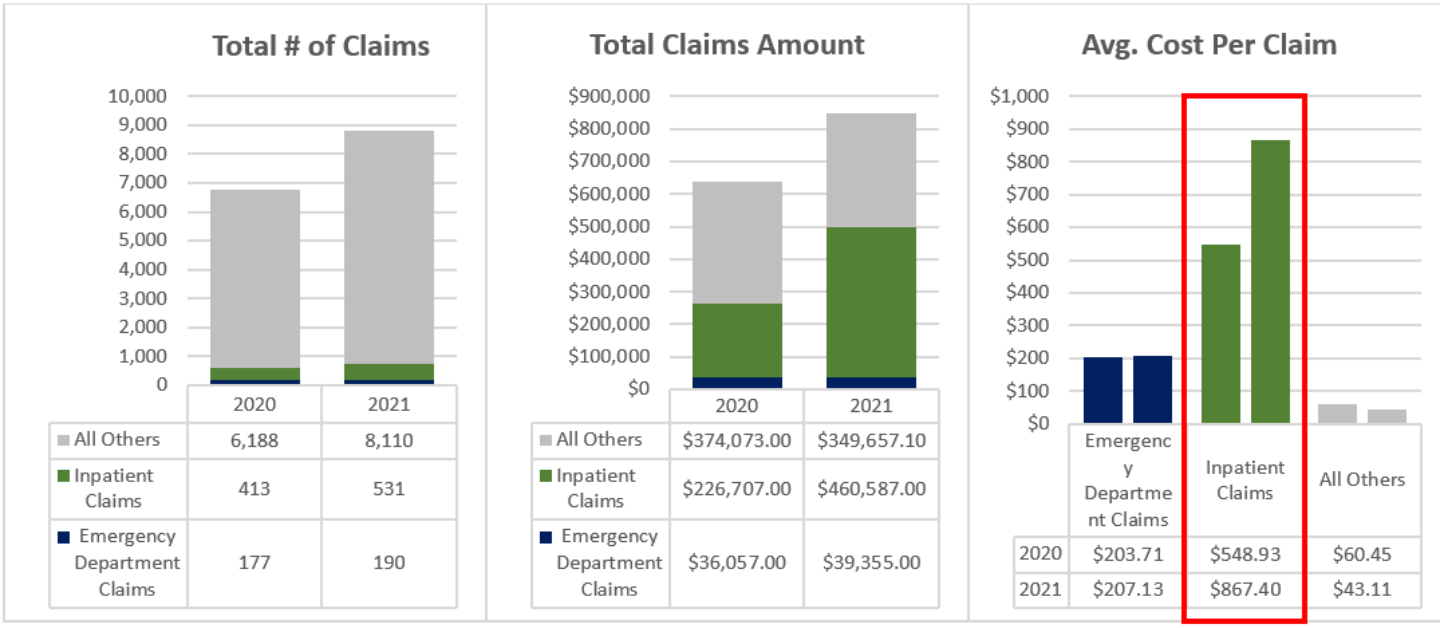
	2020			2021		
	Disease Management[3]	Case Management[4]	All Care Management	Disease Management	Case Management	All Care Management
Stratified[1]	375	1063	1268	239	1476	1565
Engaged[2]	137	725	745	137	999	1019
Engagement Rate	36.53%	68.20%	58.75%	57.32%	67.68%	65.11%

1. Stratified: PPP stratifies members for outreach, not all identified route for outreach.
2. Engaged: Members who complete a Care Management assessment are considered engaged
3. Disease Management includes Asthma, Diabetes, CAD, COPD, and HF
4. Case Management includes: Cancer, ESRD, Maternity, Pain Management, Rare Disease, Transplant, Care Coordination, Complex, Post-Hospital and Pediatric cases.

Readmission Rates

Readmission Rates
Authorization based

	2020	2021
Total inpatient admissions	1,858	1,909
Total inpatient readmissions	205	184
Unique members	125	118
Average inpatient probability	7.0%	7.0%
30-day readmission rate	11.0%	9.6%



D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

YCCO was able to accurately use MEPP data from 2020 to 2021 to identify members with diabetes requiring additional care management interventions based on their utilization patterns. This work was limited due to staffing to members with greater than 10,000 dollars in claims for 2020-2021. YCCO is planning a significant increase in scale by reviewing all members with greater than 1000 dollars in claims for care coordination or case management needs. The member will be reviewed for emergency and inpatient utilization, comorbidity and SDOH-e needs to attempt to identify those who would benefit from education and additional supports. In addition, YCCO will evaluate PCP clinics with 5000 dollars or greater average member costs related to diabetes and provide education on programs and care management available in their communities. This will be accomplished with specific outreach to care coordinators or traditional health workers that are available in the clinics.

By utilizing the existing health services program, YCCO is accessing staff that have the clinical knowledge to accurately triage and identify members who have the highest potential to be compliant and benefit from disease education and care management interventions. YCCO is also able to leverage the provider engagement expertise to work more effectively with PCP clinics and specialists to ensure the member's full care team is engaged in their disease management. Previously, YCCO was limited in the number of members that could be reviewed and outreach completed. With the 2022 strategy, there will be significant expansion to the scale of the diabetes program and use of MEPP data.

YCCO will review all members with greater than $1000 of diabetes related claims for coordination needs. All members with two or more related emergency room or inpatient hospitalization will be invited to the Diabetes Care Management program. Their PCP clinic will also be provided information on the program and direct contact information to YCCO Health Services Specialist.

Success Indicators:

Achievement of 100% of identified members receiving invitation, and 50% of those identified members participating in the diabetes care management program. 100% of the PCP clinics identified with >$1000 of member costs will receive outreach to alert them of Care Management resources, and providers will document an intervention added within their clinic to provide additional support to diabetic members.

Population: Members with Diabetes and AAE greater than $1000 as of December 31, 2021. Identified: Members are identified within the MEPP platform when filtering by "Diabetes" and "Highest AAE," and supplemental information will be pulled out of the YCCO Data Warehouse to fill in potential information gaps.

The data from MEPP is related to long-term complications from diabetes. The intervention work identifies members for engagement and outreach, and to facilitate the connection between members and Care Management structures. Primary data used: Members identified within the MEPP platform who have been identified with the top diagnosis codes within with AAE threshold.

Key implementation steps:

Care Management structures were bolstered during 2020 and 2021.

Staffing resources were added.

Outreach activities increased.

How will proposed project impact quality, outcomes, or utilization:

Increase the quality-of-care management outreach services and to decrease acute utilization related to AAE.

How will findings and results be tracked:

The results will be tracked in total on the Diabetes AAE spreadsheet, with additional documentation provided from CIM 3 care management program notes and clinic specific trainings. A copy of the invitation letter and clinic follow up letters will be provided.

E. **Brief narrative description**:

Hospitalizations, complications, and emergency department utilization is higher for members diagnosed with diabetes. Although the underlying reasoning are yet to be fully understood, there appears to be a clear sign of less primary care engagement and preventative activities within a the relatively small population. The equitable PAC dollars included for association are for the 609 identifiable members with PAC and active enrollment.

The intervention strategy is to expand the YCCO's new case management program/processes, targeting those members identified with a diabetic episode and quantifiable PAC. The 471 currently enrolled members identified with a Diabetes related PAC will be targeted for more frequent HbA1c testing and primary care engagement.

Gender	Count	%
M	67	47.5%
F	74	52.5%
Ethnicity	**Count**	**%**
ASIAN	2	1.4%
CAUCASIAN	72	51.1%
HISPANIC	23	16.3%
NATIVE AMERICAN	3	2.1%
OTHER	41	29.1%
Language	**Count**	**%**
English	118	83.7%
Spanish	23	16.3%

301 YCCO members received Care Management support for Diabetes in 2021. The work in 2022 should allow for an increase in this rate. The Improvement interventions listed in section F should lead to a demonstrated improvement at the next designated reporting period for this work.

Activity 1: Care Plan sharing (data information exchange)

Activity 2: Case Manager consultation (IDT) with each member

Activity 3: Network Asset Review (asset map) – Examining the specialty network that would serve and provide care for Diabetes Management

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Care Plan sharing via data information exchange

☒ Short term or ☐ Long term

Monitoring measure 1.1	Sharing of Care Plans via data information exchange			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Care Plan sharing does not currently exist via data information exchange	Care Plans are being shared between YCCO and PCPs and Specialists as a means to better manage the diabetic and dual eligible population	10/2022	Care Plans available in CIM (data exchange and claims system) for all members in this population who are engaged in CM.	03/2023

Activity 2 description: Case Manager consultation (IDT) with each member to support upstream health improvements

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Number of members identified in this population who have Case Management offered and number of members engaging in Case Management.

Monitoring measure 2.1	Care Management will provide numbers of members who receive this outreach			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Case Management is not currently offered to the entirety of this population. Currently 301 of 471 identified members are engaged with CM. (63%)	100% of the members in this population directly offered Case Management	07/2022	75% of the members in this population engaging in Case Management	12/2022

Activity 3 description: Network Asset Review (asset map) – Examining the specialty network that would serve and provide care for Diabetes Management

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: % of network who receives guidance on how to use the directory

Monitoring measure 3.1	Tracking of communications out to the network and attestation of receipt			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
During 2021, YCCO was able to develop a Provider Specialist Resource Directory and hire a Provider Engagement Supervisor to build	YCCO will complete the Provider Specialist Resource Directory to include endocrinology clinics with specific contact information for care	07/2022.	100% of network will be informed of the Resource Directory and how to utilize it	3/2023

and manage the Specialist network.	coordination and escalation. This Directory will include filtering ability to identify providers with additional supports such as alternate language and cultural strengths, BH supports, THWs in clinic, etc.			

A. **Project short title**: MEPP New Episode for 2022: Population Management focus for Hypertension

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project

If continued, insert unique project ID from OHA: N/A

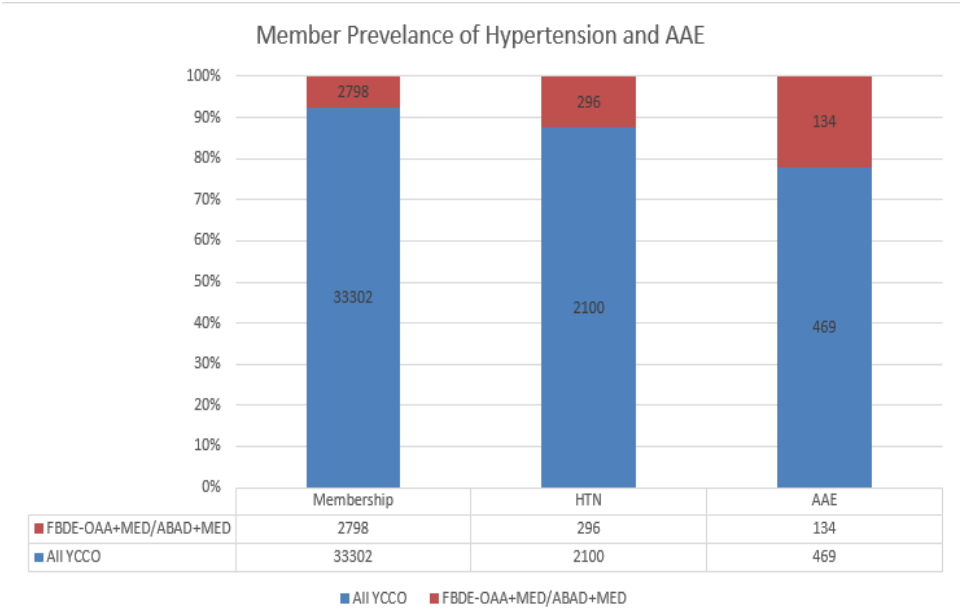
B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): SCHN: Full benefit dual eligible
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

As defined by the Center for Disease Control (CDC) and National Institutes of Health (NIH), hypertension also known as high blood pressure is a condition in which the blood vessels have persistently raised pressure. Left uncontrolled, hypertension increases the risk of heart attack, heart failure, kidney disease, stroke, cognitive decline, and other serious health problems. Often called the “silent killer,” hypertension does not always present with signs of illness that can been seen or felt and health risks increase with age.

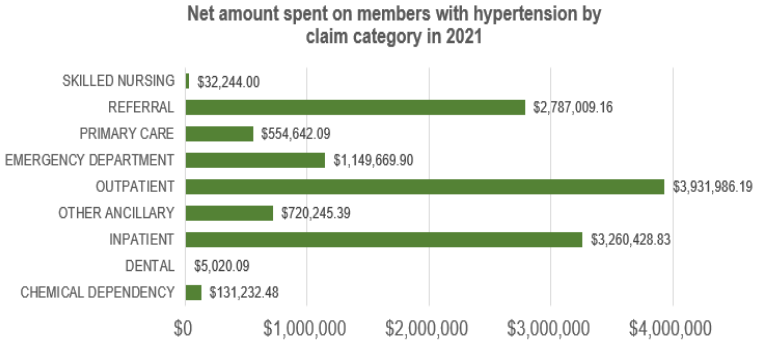
YCCO covers over 33,000 lives in Yamhill, Polk, and Washington Counties in Oregon. Approximately 2798, or 8.4% of membership are older adults with defined special health care needs (SHCN) and qualify for both Medicare and Medicaid coverage. This population, known as Full Benefit Dual Eligible (FBDE) members have a higher prevenance of hypertension at 14.1% compared to all YCCO members at 6.3% based on claims. A study of the adverse actionable events (AAE) associated with hypertension found that 45.3% of FBDE members who have a diagnosis of hypertension have AAE compared to all YCCO members with the same condition having half the AAE at 22.3%.

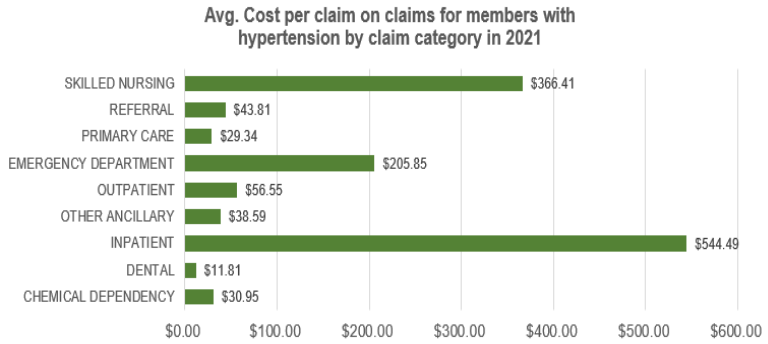


What MEPP data is being used:

A study of the costs associated with adverse actionable events (AAE) for members who are full-benefit dual eligible plan members with hypertension (296 members) found there was an estimated $259,935 of opportunity to improve. AAE information from the MEPP dashboard, filtered to the top 10 diagnosis codes with the highest AAE associated for hypertension.

Care Management services exist for all members including members who are identified as having special health care needs, who are older and are eligible for dual benefits from Medicare and Medicaid, and who are living with chronic conditions that impact their health and wellbeing day to day. While care management services wrap around all members, working with individuals who have multiple points in their care experience such as a primary care doctor, specialists, care managers, home, and facility-based care givers, can be challenging and lead to gaps in care. Through the assessment of quality and performance of utilization for members who have a diagnosis of hypertension, YCCO found that inpatient services are the second largest care type with these services having the highest average cost per claim.





How will project impact Quality, Outcomes, or Utilization:

Increasing a focused care management and coordinated approach with the primary care provider, specialty providers, and therapeutic management will keep members out of the hospital for the identified AAE.

How will results and findings be tracked:

Root cause data exercise identified members having a hypertension diagnosis for 2021 minus exclusions, and includes their MEPP numbers from 2018-2020 where applicable, and basic claims data (net amount, count of claims, avg. cost per claim) for 2021 and their current assigned PCP. Median amounts for these are as follow:

- Median amount spent per member - $1,736.69
- Median count of claims per member - 52
- Median cost per claim per member - $40.40

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

The overarching focus for this project is to provide coordinated support with primary care providers and care managers for the ongoing treatment and care support for hypertension. The goal is to positively impact the entire population with a diagnosis of hypertension and will focus specifically on the coordination barriers that exist within the multiple systems of care for the population of members who are FBDE and who have specific healthcare needs. This kind of intervention requires payers, providers, multi-discipline care teams, and care givers to work together in innovative ways.

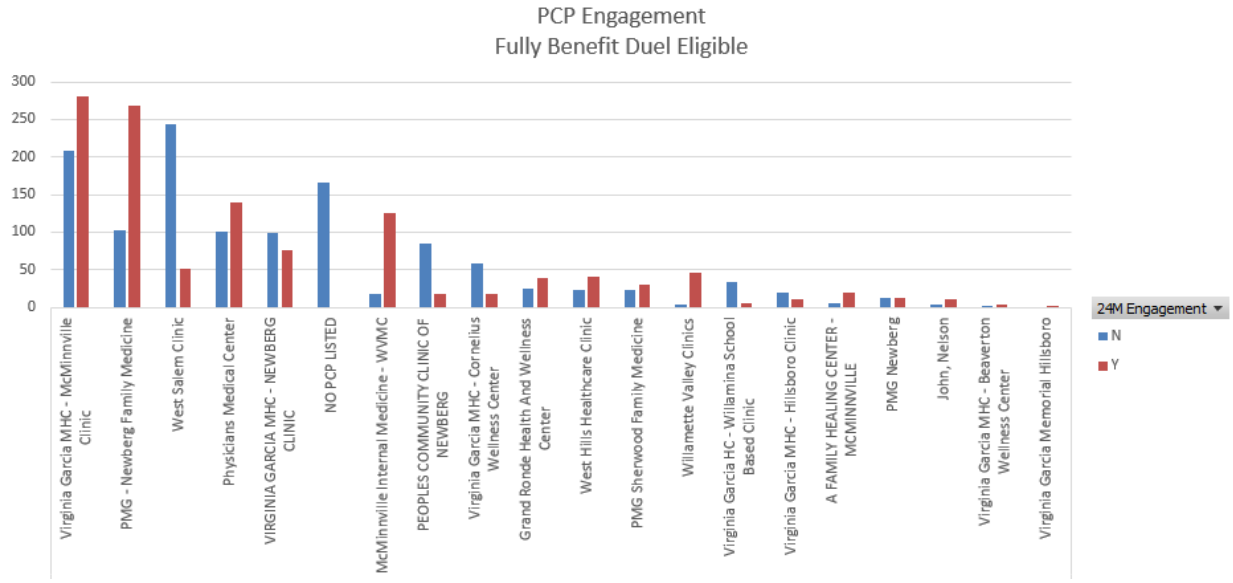
To do this effectively, a few conditions must be in place:

- Engagement in patient-centered care treatment planning
- Structured communication among the multidisciplinary care team
- Transparency and data sharing

Over the past year, efforts to intervein upstream have expanded the offering of chronic disease care management programs; data sharing between the plan, its affiliated Medicare Advantage program, and care managers; and continuous tracking of hypertension control through Electronic Health Record (EHR) data. Opportunities still exist to strengthen the collaborative development of treatment plans and supporting safe and coordinated transitions when they occur to or from an inpatient stay, skilled nursing facility, or outpatient specialty follow up.

YCCO will engage in a population management focus, featuring a multi-pronged approach:

- Identification and coordination with PCP treatment planning – An assessment of 2021 PCP engagement rates for FBDE members found 51% of members engaged with their assigned PCP in the past 24 months. This leaves 49% of FBDE members not engaging in primary care services.



- Bolstering Care Management tools focus on specialized chronic disease management programs
- Use of clinical staff for therapeutic medical management.
- Primary Care data transparency focus – Providers currently submit Hypertension data from EMRs to YCCO. YCCO will turn that data back around to providers on how well they are managing these members. This will also help to identify members who need additional Care Management support. This information to be shared at 100% of Spring 2022 site visits.
- Currently, clinics provide monthly Hypertension EMR/EHR data per requirements for CCO Incentive Metric tracking and submission. Many of the clinics that provide this data are large organizations with central reporting structures or entities. Potential gaps exist in the ability for the individual providers in those larger organizations to act upon reporting information.
- YCCO will engage in internal data analysis and targeted information development to create clinic-specific gap lists for the members who are out of control. YCCO will also support clinics with Meaningful Use for hypertension data. This information will then be shared back with the clinics to help with upstream intervention for potentially high dollar claims.

E. **Brief narrative description**:

The project activities will increase collaboration between health system partners (CCO, Affiliated Medicare Plan, local AAA/APD partners) to align PCP assignment, case manager coordination, and facilitate care transitions with the goal of providing comprehensive care that reduces the need for costly AAE, adverse health outcomes related to care transitions, and readmissions that lead to medication errors and breaks in care continuity.

Implementation Steps:

- Center the primary care provider in the coordination efforts and aligning treatment plans among all providers and care givers as an essential link to address unwanted utilization and increase responsive treatment and monitoring of hypertension. For older adults with special healthcare needs and who are blind and disabled, engaging members is essential among the various partners across the care

continuum. Communicating and sharing data to coordinate the assigned PCP, assigned case managers, and with payers.

- Focus care management outreach on members with AAE. Take top 10 diagnosis codes from MEPP and integrate into YCCO's data warehouse. Analyze member data and identify members with over utilization of acute care services and areas of underutilization of primary care services to determine care management need.
- Coordinate services to identify current processes and capacity to support medication management and reconciliation.
- Aggregate received EHR, care management, and care plan data and develop reporting to share with all relevant stakeholders.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Individualized technical assistance and data sharing to support clinics in the Meaningful Use of hypertension eCQM data.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Hypertension metric data tracking			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12/31/21 67.1% controlled	2% increase Hypertension control over baseline	12/31/2022	Established population management through structured data systems	07/2023

Activity 2 description: Share data with partners to best coordinate across the system of care including engagement rates, utilization, over utilization of AAE, care management rosters, communication points of contact.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Change in AAE			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
45.3% of FBDE members with a dx of hypertension have AAE	5% decrease of AAE for FBDE members with hypertension	12/2022		

Activity 3 description: Connect members to PCPs and intensive care coordinators to support chronic disease management.

☒ Short term or ☐ Long term

Monitoring measure 3.1	PCP engagement rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12/31/2021 51% FBDE members engaged with PCP in past 24 months	Increase PCP engagement to 60%	12/2022	24-month engagement rates 70% of higher achieved and maintained	2023

☒ Short term or ☐ Long term

Monitoring measure 3.2	ICC referral and engagement rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12/31/2021 Referrals for ICC services for FBDE members not tracked specifically	Referral and engagement data tracking systems in place	06/2022		

Activity 4 description: Post discharge follow-up and/or therapeutic medication management for FBDE members who have a care transition.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Count of members who received post-discharge follow up and medication management support from PCP, ICC, clinical pharmacy			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current baseline known	60% of members	12/2022	Add text here.	Add text here.

A. **Project short title**: MEPP Episode 3: Increased Number of SUD Providers Under Long Term Contracts

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: N/A

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No

v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

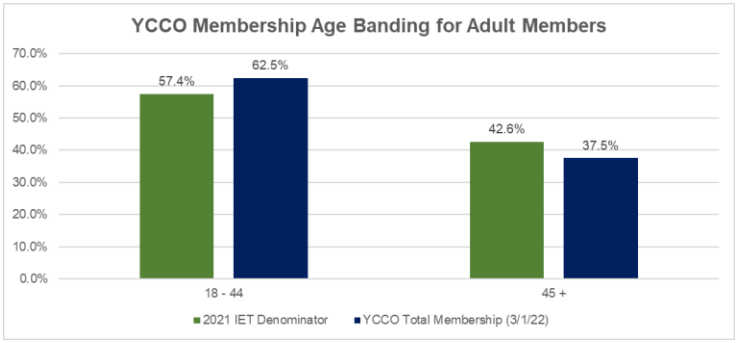
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

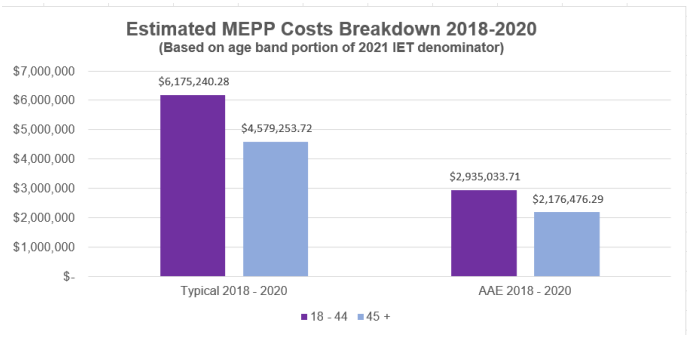
The YCCO intervention strategy is to invest resources and efforts in improving the current SUD provider network, both in number of providers, scope of contracted services, targeted quality outcomes, and contract payment terms. Alcohol and opioid related services will be prioritized, as well as analyzing the historical use of single case agreements versus contracting and partnering with providers. To complete this necessary work, YCCO planned to acquire the equivalent of 1.6 FTE in new staffing for purposes including SUD network development, contracting, and engagement. After struggling with hiring these positions (including hiring a Behavioral Health Systems Specialist 3, and then losing that staff member soon after) YCCO was able to hire a Provider Relations Supervisor and a Health Services Specialist in 2021, each who have a focus on the Behavioral Health network and quality improvement work within that space.

For 2020 and 2021, the approach shifted in response to the COVID pandemic. The focus moved to the ability to get SUD and other BH services and supports to Members. YCCO and the LMHA/CMHP/YCHHS worked closely together to identify support needs for both Medicaid and non-Medicaid individuals. System improvement efforts have included expansion of services provided by practitioners outside of the CMHP. This expansion has shown an increase of 1,153% since the inception of YCCO. SUD related investments include youth and family advocates, SUD engagement/support peer services, partnerships with law enforcement (Community Outreach Specialists), increased access to MAT services, and referral pathways/warm handoffs with the Yamhill County jail. SUD/BH services were expanded in the schools in 2020, adding two part-time counselors, and a 1.0 FTE was added in 2021 specific to the Newberg school district.

The original estimate of potential savings using the revised MEPP dashboard and 2017-2019 data are now $1,359,000. Updated potential costs are still under review, as 1) some costs have just been delayed as part of delays in recruitment, and 2) delays in actual contract negotiations and execution with providers which will inform the magnitude of any changes in provider reimbursement.

An age-banding exercise took place as part of the recap of the previous years. The topline conclusion is that members in the IET denominator are disproportionately older than our membership as a whole.





D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

The focus of this intervention is to increase the number of contracted providers. This work is ongoing and is a long-term QI effort. SUD system improvement will be implemented via Project 2 of YCCO's Comprehensive BH Plan Workforce Project. This project centers around enhancing workforce competency through development and implementation of

targeted training curriculum. 2020-2021 work focused on transitioning between administrative entities and conducting assessment of system. SUD providers have been prioritized based on service utilization patterns. Work for 2022 and beyond will center around building structures within this space to expand service availability and provide resources for expanded provider panel.

Direct contracting is a focus of this project from the standpoint of an increased contracted network and fewer single case agreements. This will allow for better quality monitoring of the network, with downstream impacts to overall member health, and specifically within areas identified as AAE within the MEPP platform. A specific contracting workgroup has been formed to aid in structural building of this process and to align around best practices.

The population of focus is the upstream membership who do not have a AAE as a preventative measure, and the aggregated membership identified as having AAE within the MEPP system.

Assessment of the MEPP data provides insight by identifying the top AAE diagnosis codes into the physical health impacts of drug and alcohol use. In order to address these impacts YCCO is looking upstream of the hospital impact and address the larger community-based system. By increasing the number of practitioners available YCCO seeks to increase the impact of critical services to address addiction among YCCO members.

Key Implementation Steps:

As part of the Comprehensive Behavioral Health Plan, a deep dive analysis has been completed, focused on reviewing the SUD providers in network as well as SUD providers who are out of network, who have provided services to YCCO members.

How will the project impact Quality, Outcomes, or Utilization:

YCCO expects that this will impact utilization by increasing capacity and member choice regarding SUD service providers.

How will results and findings be tracked:

Foundational core element that will be tracked is the number of contracted SUD providers. Longitudinal results will be tracked based on the percent of members who receive a service from a contracted provider. Will be assessed against implementation to determine increased service usage.

E. **Brief narrative description**:

The overarching QI work to happen in 2022 is to develop stronger referral pathways for specialty providers and services.

A large-scale improvement tool will be the development of a Service Resource Directory, which will be an aid in connecting and coordinating better communication between provider groups. Increased coordination and communication will bolster upstream disease and health management and lessen costs for the system in the longer term.

The work done in 2022 will provide the ability for Care Management and other staff to search specifically by subspecialties within SUD, location, and other more helpful filters. This tool will facilitate utilization in order to effectively connect members to the right provider(s) (especially within CM and customer service) and to easily find providers with necessary sub-specialties.

As part of ongoing quality structures, YCCO will engage in a review of utilization patterns mid-year in 2022, to demonstrate the impacts of larger contracted network and increase in SUD costs (which will decrease avoidable costs down the line).

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Develop Service Directory.

☒ Short term or ☒ Long term

Monitoring measure 1.1	Service Directory subcommittee will provide progress reports to internal UM Committee and MEPP Committee			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current resources, such as the Provider Directory and DSN, do not allow for the level of finesse in filtering for sub-specialties and other more detailed information, in order to more effectively pair member need with specific providers	Develop resources for expanded service provider guide	10/1/2022	System integration with Provider Directory and DSN	3/2024

Activity 2 description: Implement bolstered referral pathways (primary care resource for SUD referral processes).

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: SBIRT Metric – Rate 2.

Monitoring measure 2.1	Metric rate tracking through data submission by clinics. Utilization rate tracking of claims by contracted providers.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2021 Data: Rate 1 – 56.3% of people who had visit received screening Rate 2 – Based on positive screen 34.1% were referred into treatment	Improve rate 2 by 3%	12/2022	Decrease the percent of members served by a non-contracted provider by 50% 50% decrease in the number of non-contracted providers who served a YCCO member	3/2024

Section 2: Discontinued Project(s) Closeout

A. Project short title: MEPP Episode 2: Increased Engagement Within School-Based Programs

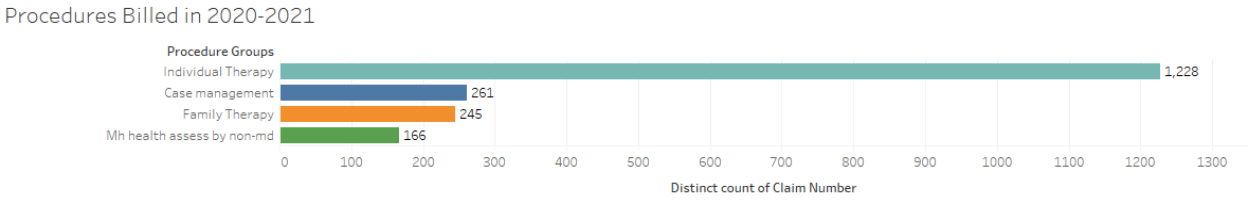
B. Project unique ID (as provided by OHA): N/A

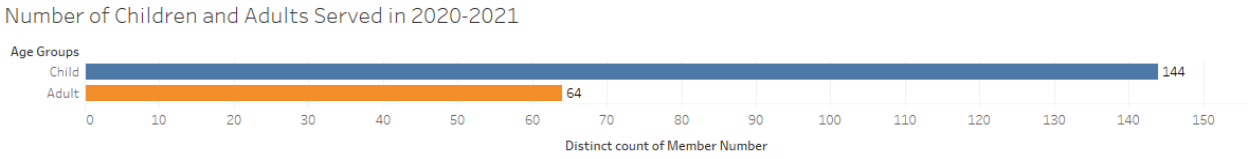
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes.

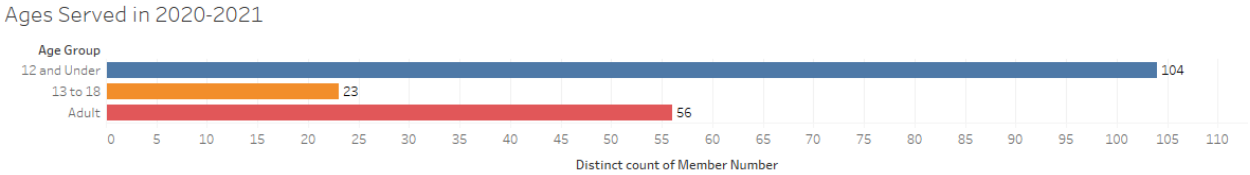
D. Reason(s) for project discontinuation in support of the selected criteria above:
MEPP Episode 2: Increased Engagement Within School-Based Programs was intended to be of limited duration with the primary focus being on establishing funding to increase the number of clinical practitioners available to provide services to youth in the school setting. Once established and stabilized, no new intervention was planned as the impact of the original intervention will naturally evolve over time without additional interventions. This project was included for one year longer than originally anticipated due to the impact of COVID on implementation. Additionally, YCCO is seeking to align efforts with larger statewide efforts, including those driven the CMS waivers.

Additional information requested:

The intervention of "Increased access to on-site behavioral health services to children within the public school system, provided by increased FTE/providers" was met. The baseline for services provided by new providers was zero services provided. The intervention of increased FTE/providers increased the services provided to greater than the baseline. It should be noted that the pandemic was found to be a confounding variable adversely impacting the overall outcome. The charts below demonstrate service delivery by the "increased FTE/providers":







A. Project short title: **Integration of PCP and Oral Health**
B. Project unique ID (as provided by OHA): 176
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above:
YCCO worked closely with the local Oral Health Coalition to develop an educational meet-and-greet series to promote interdisciplinary connection and increase referral pathways. More than 60 providers were engaged and more than 80 received information about integrating care, delivering high quality dental services, and referring between behavioral, oral, and physical health. While these events were successful and 100% of survey respondents indicated they learned information to use in their practice, integration

activities weren't being formed because of these events. The Oral Health Coalition shifted its priorities from increasing provider connections and awareness to moving into a place of action. The project achieved its goal of increasing awareness of referral between physical health and oral health providers, and will be discontinued. New projects will build on this awareness to increase actual activities related to integration.

A. Project short title: **Primary Care Capitation Pilot**
B. Project unique ID (as provided by OHA): 408
C. Criteria for project discontinuation: Project fails to meet TQS requirements for the chosen component(s) based on OHA feedback and/or written assessment
D. Reason(s) for project discontinuation in support of the selected criteria above:
Per OHA feedback, this project met the Access: Quality and Adequacy of Services component but lacked enough specific tie in for the PCPCH and UR elements. As a result, YCCO has pulled this project from the 2022 TQS, while incorporating those Components into other/new projects. This pilot work is ongoing and focuses more on clinic engagement when capitation payment arrangements are in place.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).

1) **YCCO Quality and Clinical Advisory Panel Charter**
2021 Review and 2022 Planning QCAP Presentation
QPI-001 Quality Program and Performance Monitoring
YCCO Policies and Procedures

2) Quality Assessment Performance Improvement Annual Monitoring:
Grievance System 2020 Annual Report
2021 Metrics – Preliminary Final
2021 CDC SLA
2021 CM Audit Final
2021 PH Tech SLA
2021 Providence SLA
Subdelegate Oversight
2021 Q1 YCCO Behavioral Audit Findings
2021 Q1 YCCO Physical Health Audit Findings
2021 Q2 YCCO NEMT NOABD Audit Findings
2021 Q2 YCCO Physical Health Audit Findings
2021 Q3 PHTech PPP Audit Findings
First Transit Wellride Credentialing Audit 2021
PPP Credentialing Audit 2021
PPP Credentialing File Review Tool 2021
CDC Credentialing File Review Tool 2021

YCHHS Credentialing File Review Tool 2021
YCHHS Credentialing Audit 2021

3) **YCCO QCAP Minutes 1-25-22**
YCCO QCAP Minutes 2-22-22
YCCO QCAP Minutes 11-23-21
Compliance Committee Minutes 06-24-2021
Compliance Committee Minutes APPROVED 2021.11.30

B. OPTIONAL: Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.
   - **2022 TQS Projects Matrix**

C. OPTIONAL: Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Add text here.
   - **YCCO Member Demographics**

Submit your final TQS by March 15 to CCO.MCODeliverableReports@state.or.us.

Revision History:

Revision 1 – 06/02/2022:
Updated Diabetes success indicators in section C per ASU request (MEPP Deliverable), to demonstrate success of the project
Updated School-based BH MEPP project closeout to include success indicators per ASU request (MEPP Deliverable), to demonstrate success of the project